The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-FIVE *NUMBER ONE*

MONTREAL, JANUARY, 1949

Talking with a Purpose

IT'S MONDAY evening. The radio is tuned to a Trans-Canada network station. There is a pause and then the announcer says: "This is the National Farm Radio Forum . . ." Some of their neighbors have joined the Wilson family and are seated around the table in the cosy kitchen listening to the discussion on the question "Do we want more immigration?" The voice on the radio fades away and the chairman of the listening group explains for the benefit of the new-comers that the Farm Forum is a group of neighbors who meet once a week to listen to the National Farm Radio Broadcast, to study and discuss the topic of the broadcast, and to decide how their problems can best be solved, then to follow up with appropriate action.

The techniques include: (1) A radio broadcast each week on a C.B.C. national network; (2) printed study material containing background information on the broadcast topic and distributed to the forums a week in advance of the broadcast; (3) group discussion by the forums on the subject of the broadcast; (4) a summary of the findings as reported by the forums and summarized by provincial secretaries each week on a provincial five-minute newscast.

The chairman explains that the secret of having a good forum meeting

GERTRUDE M. HALL

is the same as for a party. There must be a good crowd—everyone must take part—everyone must have fun—everyone should feel afterward that the evening was well spent. People enjoy a party or a meeting better if they get into the thick of it—if they are divided into small groups at a meeting, they will all take part. The chairman of the forum then proceeds to divide the members into groups of five to eight people. Each small group chooses a chairman to lead the discussion and a secretary to take notes; afterwards the groups come together again and the secretaries report the conclusions. Further discussion usually follows in the big group under the leadership of the forum chairman. "It is most important that people feel the meetings are worthwhile," said the chairman. "If they have a sense of accomplishment at one meeting, they will come back to the next." He continued, "Two things are vital":

1. *The discussion must arrive somewhere.* The chairman should always summarize it at the end. If the group does not agree or cannot reach a satisfactory conclusion, the chairman should summarize the points of agreement and disagreement. The very act of summarizing helps to clarify people's thinking and gives them a sense of achievement.

2. *Discussion should be followed with action.* For example—If the group has not been able to reach a conclusion because of lack of knowledge, it has been found advisable for the group to appoint a committee to get further information on the subject and to report back at a future meeting.

Every forum should undertake an action project during the year. Those who have followed the progress of Farm Forums believe that this unique method of adult education has made significant contributions to national unity, to urban understanding of farmers and farm problems, to the growth of rural leadership, to the development of farm organization, to the growth of co-operatives and other community action and, more important, to the moulding of public opinion and the influencing of government policy.

"But what," you ask, "has all this discussion concerning Farm Forums to do with nursing?" Those who have followed the growth and development of this form of group thinking and activity believe that many of their methods could be used to advantage to stimulate and vitalize our own associations. Quite often we hear the statement:

That all business, all the decisions concerning nursing are made by only a few people; that nurses on the whole are not interested in association meetings; too few nurses either know or care about the work of their association; that nurses on the whole are not well informed about their own affairs and, consequently, they cannot or do not give to the public whom they serve adequate or correct information.

Granted that, at least in part, some if not all these statements are true, we could, of course, spend endless time discussing the reasons thereof. Our greatest concern, however, is in finding more effective ways of correcting the mistakes of the past and of building a stronger, better, and more unified nursing organization.

Those who took part in the workshop program at the last biennial convention expressed keen interest in the group method of activity. Unfortunately, however, less than one-thirtieth of the total membership of the Canadian Nurses' Association were able to participate in this program. Is it too much to say that sufficient interest was aroused and has been sustained since so that it might be expected to carry over for the benefit of those who were unable to attend the convention? Consideration might now be given to the development of *Nursing Forums.*

It is not expected nor intended that such forums for nurses should follow in detail the exact pattern of the National Farm Forum. However desirable and glamorous it might be, we could not aspire to a weekly Trans-Canada broadcast. In this connection it is interesting to find that very successful Farm Forums are conducted in Ohio without the use of radio. As

a starting point, two questions immediately arise, both of which should be thoroughly discussed by those provincial associations, districts, and chapters interested in the possible development of forums:

1. What could a Nursing Forum do for our community?

2. Where and how might forums be organized in the district?

Having reached agreement on these points, the next step would include the preparation of suitable topics for study and the collection of material containing background information for distribution among the members of the forum. Forum questions selected for discussion must essentially be of such vital interest to nurses that they will want to talk about them. Some topics which come to mind are outlined merely as suggestions and include:

I. The following statement is contained on page 15 in *A Proposed Curriculum for Schools of Nursing in Canada:* "It is hoped that ultimately support of nursing education will be recognized as a public responsibility and schools of nursing will become professional institutions maintained by public funds."

1. What is your reaction to this statement?

2. What reasons would you advance—(a) for government support of nursing education? (b) against government support of nursing education?

3. What steps would you suggest should be taken now in this regard by — (a) your provincial Registered Nurses' Association? (b) the Canadian Nurses' Association?

* * *

II. The statement is frequently made that a great many nurses upon graduation turn away from bedside nursing to seek positions in other fields of nursing.

1. Do you accept this statement as representing the true situation?

2. What do you suggest could be done now to remedy this situation if it exists?

* * *

III. In this age of specialization, total patient care is a composite of services rendered by many individuals within the institutions: doctors, nurses, nurses' aides, dietitians, physiotherapists, occupational therapists, laboratory and x-ray technicians, clergymen, librarians, and business administrators.

1. How might we secure greater coordination of effort among all personnel to the end that total care may be smoothly and harmoniously blended into a complete unit?

2. What part can the nurse take to secure such integrated care?

3. What suggestions would you make for the pooling of ideas and sharing of experience?

* * *

IV. It has been implied by Dr. Esther Lucile Brown in her recent study and report "Nursing for the Future" that *job satisfaction* is one of the greatest factors operating to retain personnel in their respective positions.

1. To what extent do you believe an increase in *job satisfaction* to be necessary in the following fields of institutional and public health nursing: (a) general staff nursing? (b) head nurse, supervisory, and instructional positions? (c) nursing administration?

2. To what extent do you believe the augmenting of *job satisfaction* in the above fields might: (a) attract well-qualified nursing personnel to these positions? (b) retain personnel in positions, thus stabilizing nursing services and improving the quality of service rendered to patients? (c) promote the growth and development of professional nursing personnel? (d) attract increasing numbers of suitable young women to nursing?

Many other topics pertinent to nursing and of interest to nurses will, of course, be suggested by the members. It would be the responsibility of the chairman and secretary to give leadership and guidance on all matters related to the organization and conduct of the forum. It is important, too, that study material for the topics to be discussed should be prepared and available in advance for the members of each forum as stated previously. Discussion outlines, designed to systematize and direct the preparation for discussion, could profitably be prepared. The making of the outline serves to stimulate investigation, clarify thinking, and prepare the

individual to express his ideas in discussion with a minimum of confusion and lost effort. It serves to conserve the time and energy of the group and essentially paves the way for more productive group thinking. The outlines could begin with a statement of the problem and provision made for five main divisions: (1) Definition of the problem; (2) analysis of the problem; (3) possible solution; (4) tentative conclusion; (5) suggestions for putting solution into operation. Reference material might be made available by nursing associations, universities, and school of nursing libraries. *The Canadian Nurse*, providing as it does so many articles of current interest, is an excellent source of information for study groups.

It would be the function of the forum secretary to summarize the results of discussion on the various topics, and these could be forwarded to the provincial associations. This would provide a poll of nursing opinion. By having the same questions discussed by all the groups in a province or, better still, in all the groups across Canada, it would thus be possible to obtain a nation-wide sampling of nursing opinion on many important matters of the day. Can anyone suggest a better method of securing the considered opinion of nurses? Is it too much to hope that the development of Nursing Forums might some day include among its active and participating members every individual nurse in Canada? This outline of individual and group thinking on the part of Canadian nurses might well provide the key to some of our most pressing problems and thus do much to dispel the clouds which tend to obscure the horizons of present-day nursing.

GERTRUDE M. HALL
General Secretary-treasurer
Canadian Nurses' Association

National Health Week

"Guard Your Health—Know How" once again has been chosen as the slogan for another National Health Week. This is Canada's fifth annual observance of this project in the field of health education in Canada—*January 30 to February 5*.

National Health Week is sponsored by the Health League of Canada in co-operation with official departments of health and departments of education throughout the nation. The slogan "Guard Your Health—Know How" emphasizes the theme of all Health Week observances, because the event is aimed at impressing Canadians with the fact that much illness is unnecessary, that in many cases their state of health depends on themselves. All that is needed is a type of health education which is as attractive as it is informative.

It is the hope of the sponsors of National Health Week that every organization and every individual in Canada will do something to assist in the 1949 observance, and that such co-operation will eventually lead to Canada becoming the healthiest nation in the world, something which is far from being a remote possibility if everyone acquires a "know how" in health matters.

Red Cross Information Bulletin

Through the Canadian Red Cross Society, the League of Red Cross Societies is making available to Canadian nurses, at the subscription rate of $1.00 per year, the publication entitled *Information Bulletin for Red Cross Nurses*. The *Bulletin* appears in English, French, German, and Spanish. This publication, issued quarterly, carries articles designed for nurses serving in the Red Cross, but is also of interest to all nurses throughout the world as a means of sharing information on an international basis.

Those desiring to subscribe should do so by writing to: **Nursing Department, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.**

Pneumonia in Children

S. A. Boyd, M.D.

Pneumonia is an acute inflammation of the lung, resulting usually from bacterial or virus infections. While these are the common etiological agents, such a process may be induced by fungus infections, the aspiration of irritants, or prolonged passive congestion as the result of weakness and debility.

Massive involvement causing consolidation of the major part of a lobe is termed lobar pneumonia, in contrast to bronchopneumonia in which the process is more disseminated, producing consolidation of scattered lobules with associated inflammatory reaction in the adjacent bronchioles. While such an anatomical division is clinically useful it is more valuable, where possible, to classify pneumonia according to the etiological agents that produce it. Though still not ideal, the following is a useful working classification:

Pneumonia due to:

1. Bacterial infections.
2. Virus infections.
3. Mycologic infections.
4. Aspiration of irritants.
5. Hypostatic congestion.
6. Miscellaneous causes: (a) Mixed virus or bacterial infections and aspiration; (b) pulmonary infection associated with cystic fibrosis of the pancreas; (c) eosinophilic pneumonia (Loeffler's Syndrome).

The vast majority of pneumonias in children are the result of bacterial or virus infections and this discussion is limited to these types.

Bacterial Pneumonias

These are the result of invasion of the lung by bacteria, the predominating organisms being the pneumococcus, streptococcus, staphylococcus, hemophilus influenzae, Friedlander's bacillus, tubercle bacillus and treponema pallidum.

Dr. Boyd is associated with the Children's Hospital, Winnipeg.

Pneumococcal Pneumonia

The pneumococcus accounts for the large majority of all pneumonic infections in infants and children. The infection is usually primary but not infrequently is secondary to measles, whooping cough, influenza, or the common cold. Infants are especially prone to mixed infections. Anatomically, the distribution of the infection is lobar but in infants widespread dissemination of the lesions in a lobular or bronchopneumonic pattern is frequent. Clinically this is of no appreciable consequence.

Etiology: The active agent is the pneumococcus of which over seventy types have been demonstrated. Type specific serum is available for over thirty of these. In most cases the infection is due to types I, II, VI, XIV and XIX; the organisms reach the lungs through the respiratory passage from the nasopharynx. Pneumococcic antibodies, present in the blood during the first month of life, tend to disappear until the end of the first year and then increase throughout the rest of life. Lowered resistance from malnutrition and exposure are predisposing factors and the disease is more prevalent in the winter and early spring.

Pathology: The basic process is a fibrinous exudate principally in the alveoli and to a lesser extent in the bronchioles. The alveolar walls become congested, serum and inflammatory products exude into the alveoli, resulting in consolidation. This is followed by gradual liquefaction of the inflammatory process with eventual clearing of the alveoli by resolution. The initial lesion generally starts just under the pleura and is associated with inflammation of the adjacent pleura. The lobar variety is locally massive whereas in the bronchopneumonic type the lesions are diffusely scattered involving lobules.

The clinical picture: The classical picture of pneumococcal pneumonia, as seen in the adult, is seldom observed

in the infant or young child. Infants are more prone to bronchopneumonia distribution of the lesions and older children to a lobar distribution. The onset of the pneumonia is generally preceded for several days by an upper respiratory infection followed by a sudden onset of the acute illness associated with high fever, restlessness, prostration, and dyspnea. Vomiting is a common initiating symptom. Cyanosis, convulsions, and diarrhea frequently herald the onset of bronchopneumonia in infants, and meningism and lobar pneumonia of older children.

The characteristic chill observed in the adult and older child is not frequent in the young child. The temperature, abruptly rising to 103° or 104°, shows considerable daily fluctuation in contrast to the sustained fever in the adult. Respirations are rapid with shallow respiratory excursion in order to avoid the associated pleural pain. When the process is severe, the accessory muscles of respiration are utilized. This is manifested by some indrawing of the intercostal spaces and active inspiratory dilatation of the alae nasi.

Cough is markedly variable and the characteristic rusty sputum seldom is evident for the child swallows the secretion raised.

With involvement of the diaphragm, pain is frequently referred to the abdomen and the onset of pneumonia in children is commonly a surgical trap.

The earliest physical sign is suppression of the breath sounds over the involved area frequently associated with fine râles of congestion. This is usually followed by evidence of consolidation manifested by dulness to percussion and tubular breathing. As resolution appears, râles again become evident and the signs of consolidation disappear. The white blood count increases from 15,000 to 40,000 with a predominance of polymorphs. The x-ray is valuable in assessing the anatomical diagnosis.

Complications: Otitis media is probably the most common. Chemotherapy has greatly reduced the incidence of the relatively frequently-observed empyema prior to the sulfonamide era. As a result of such therapy, the rarer complications such as purulent pericarditis, peritonitis, pneumococcic meningitis, and endocarditis are now seldom observed. Abdominal distention is a serious problem in infants.

Prevention: Avoidance of contact with patients with pneumonia and the isolation of carriers of virulent pneumococci is the ideal method of prevention but not always practical. Frequent change of position of weak and debilitated infants is of special service and where secretions accumulate in the nasopharynx these should be aspirated. Where possible, it would be worthwhile to carry the long-term hospitalized infant around when feasible as a prophylactic measure.

Treatment: Rest and chemotherapy are the two most important agents in the treatment of pneumococcic pneumonia. All attempts should be directed toward conserving the child's energy. Diet need not be restricted unless there is undue abdominal distention. Adequate fluid intake should be maintained to produce an output of urine of average specific gravity to ensure the excretion of toxic products. Where necessary the fluid requirement should be given parenterally.

Sulfadiazine is the sulfanamide commonly used, with an average daily dose of 1 to 1½ gr. per pound of body weight. The initial dose is one-half of the total daily dose, and the dosage is then usually proportioned every four hours. An equal quantity of sodium bicarbonate is advisable. Sulfadiazine should be continued for several days after the temperature has become normal. During the course of therapy, blood counts and urinalyses should be checked every second day. A rapid fall of the white blood count below 5000 per cu. mm. demands cessation of the drug.

Penicillin in dosage of 10,000 to 15,000 units every three hours is effective but discomforting, and should be reserved for the child whose white blood count is low or who is known to be sensitive to the sulfonamide.

Oxygen is often a life-saving measure

and is indicated where dyspnea causes extreme restlessness or when slight cyanosis is present.

Enemas and the rectal tube are useful where moderate degrees of abdominal distention are present. These may be greatly aided by the subcutaneous injection of prostigmine in a dosage of 0.5 to 1.0 cc. of a 1 to 4000 solution.

Other Bacterial Pneumonias

Streptococcal and staphylococcal pneumonias are usually secondary to some other infection such as measles, whooping cough, influenza, or the common cold and generally are bronchopneumonic in type. Hemophilus influenzae produces a bronchiolitis with associated bronchopneumonia. Friedlander's bacillus is relatively rare. Therapy should be directed along the lines of that of pneumococcal pneumonia.

Virus Pneumonia

In the past decade, this respiratory infection has become prominent, especially in older children and young adults, and has been attributed to several different varieties of virus.

The onset is usually gradual and manifested by malaise and slight cough, which increases in severity and may become productive of a blood-streaked sputum. Within a few days the temperature may rise, usually to 102° or 103°. Headache and substernal pain are common and dyspnea may appear. The older child does not usually appear as ill as his fever would indicate. Physically, râles are heard in isolated areas and radiologically the x-ray shows quite marked changes with evidence of diffuse infiltration extending from the hilar region in a fan-shaped fashion out to the periphery. In contrast to bacterial pneumonias the white blood count is low.

Treatment is entirely symptomatic. The condition does not respond to sulfonamides or penicillin. Phenobarbital may be useful in producing rest and codeine may be necessary to control the cough. The acute phase usually lasts for about eight to ten days but convalescence for a longer period is generally necessary for x-ray evidence of the lesion may persist for several weeks.

Care of the Infant with Pneumonia

Marjorie Rideout

During the winter months more and more infants with pneumonia are being admitted to hospitals. This disease is an inflammation of the lung which may involve all the alveoli of one lobe (lobar pneumonia) or it may involve various parts of the lung (broncho-pneumonia or lobular). It may be caused by any pyogenic bacteria and in some instances by a virus. It may be of a primary or secondary nature.

In pneumonia the function of the lung is impaired. The alveoli become filled with exudate, causing shallow breathing, which in turn causes poor oxygenation of the blood. The oxygen content of the arterial blood is reduced, thus giving symptoms of anoxia. The greater the anoxia the more shallow the breathing. Anoxia produces cyanosis, dyspnea, and cerebral symptoms, including delirium and inability to sleep.

Signs and symptoms of pneumonia:

Sudden onset; fever and prostration; convulsions may occur at onset or chills; anoxia with cyanosis and dyspnea; rapid respirations—60 to 70 per min.; rapid pulse rate—160 or more; râles in the lungs; cough frequent,

Miss Rideout is a recent graduate of the Royal Victoria Hospital, Montreal.

persistent, and annoying; restlessness; mucus in lungs and throat; vomiting occurs frequently; moderate diarrhea.

On admission the infant is given routine admission care by the nurse. This consists of taking the temperature, respirations, pulse, and weight, careful observation of infant's skin, mouth, throat, nails, nose, ears, head, and any abnormalities. The infant is then given an admission bath unless contra-indicated.

The doctor makes a physical examination, Mantoux test, takes a white blood count, hemoglobin, and blood Wassermann. The chest is x-rayed as soon after admission as possible, frequently before any medications are given. X-rays may be repeated during the infant's stay in the hospital and are always taken before discharge. Throat cultures are sent to the laboratory to determine the type of bacteria causing inflammation.

Treatment today depends on chemotherapy in the form of sulfonamides and penicillin, resulting usually in a shortened illness and convalescence. The amount of sulfonamide given varies with the patient but should be such as to maintain a blood level of 5-13 mgm. for each one hundred centimetres of blood. This drug is given in a solution as it is easier to administer and more prompt in action. Penicillin is given intramuscularly, the approximate dosage being about 15,000 units every three hours with an initial dose of 30,000 units. In severe cases the dosage is usually higher, up to 60,000 units every three hours. Medications are continued until the temperature has been normal for seventy-two hours or until the chest has cleared satisfactorily. The medications may be given separately or together. Ephedrine ½ or 1% in normal saline is given as nasal drops if there is much discharge.

The infants are placed in cots on either the right or left side, with a small, covered sand-bag placed at the back to keep him in this position. There is always the danger of aspirating mucus or vomitus if vomiting is present.

In cases where respirations are very labored, the infant may be propped in a sitting position with a pillow at the back for support. To maintain this position and prevent slipping down a small rolled blanket or sand-bag may be placed under the knees.

Oxygen is administered when cyanosis is present or respirations very labored. It may be given by funnel. This consists of a small granite funnel attached to the oxygen tank by a piece of rubber tubing. This method is good if the infant is small or inactive. If he is active it is difficult to keep the funnel in place. The other method used is by "box" which is a small, open-top, rubber box connected to the oxygen tank by rubber tubing. Oxygen running directly into a croup tent often makes it very hot and the air dry. If this occurs the oxygen may be run through a bottle of distilled water. The concentration of oxygen used depends on the patient but is usually around 40-60 per cent.

All cases of pneumonia are put on modified isolation, which means that the nurse wears a gown over her uniform while caring for the infant. The hands are scrubbed for one minute before removing gown and for two minutes after. If possible all patients are placed in cubicles.

Sponge baths are given if the temperature is over 104° rectally. The reaction temperature is taken twenty minutes after the sponge. Sponges are continued at intervals until temperature is lowered.

Croup tents are used when the infant has a dry irritating cough which causes restlessness and discomfort. The purpose of the tent is to moisten and warm the air which the infant is inhaling. When special tents are not available, a make-shift can be made by placing sheets over the head and sides of the cot. A kettle containing water is placed on a small electric stove which should be on a firm foundation at the side of the cot. The spout of the kettle is directed into the cot in such a way that the direct flow of steam is not near the infant as there is always danger of burns. Infants who are active should be restrained or a protective screening placed

at the side of the cot to prevent him from reaching the stove or kettle.

Feeding the tiny pneumonia patient usually presents a problem as his mouth may be filled with mucus or his respirations so difficult or rapid that he is unable to eat. Sometimes both conditions are present making feeding a very difficult problem. The mucus may be removed quite easily by suction, which may be a baby suction or of the motor type. The suction tip should be placed well back in the infant's mouth. Infants having excess mucus should have the suction applied before and after feeding. The infant's nostrils can be cleaned with swabsticks and should always be clear when feeding as this is its only air passage.

Infants may be fed by medicine dropper or Brecque feeder if they are not able to use an ordinary bottle and nipple. Feedings are frequent and small as the infant becomes very tired. Sterile technique is observed throughout any of these methods. Feeding infants in this manner requires much time and patience on the part of the nurse. Babies who present feeding problems are first given small amounts of 5% glucose and water, then started on a weak formula which is gradually increased in both strength and amount.

The nurse must be constantly on the watch for signs of dehydration in infants who are not taking their feedings well. The signs of dehydration are: dry, loose skin, which when picked up returns very slowly to its original position, depressed fontanels, sunken eyes, and green stools. These signs should be reported immediately so that he may be given an intravenous to supplement the fluid intake.

The infant should be kept warm as chilling hinders the recovery and may cause complications. Complications may occur even when careful treatment has been carried out in every detail. These are usually secondary infections such as otitis media, pleurisy, meningitis, and peritonitis.

The infant is bathed daily to keep skin clean and in good condition. Oiling the skin slightly keeps it soft and prevents skin irritation. Keeping the baby dry is very important for as soon as he is uncomfortable he cries, exhausting himself. The buttocks often become red and irritated, even with the best of care. Zinc oxide ointment may be applied with very good results. The weight is checked daily, for a baby who is gaining is on the road to recovery.

The prognosis is good, especially if treatment is started early.

Nicotinic Acid in Treatment of Chilblains

According to Gourlay, writing in the *British Medical Journal*, the usual sites of chilblains are the dorsal aspects of the proximal phalanges of the hand, the plantar aspect of the toes, along the inner border and dorsum of the great toe, and in the region of the heel and achilles tendon. Chilblains may also occur on the ears, but in this site they resemble frostbite rather than a true perniosis. The gross pathology of the chilblain lesion is a vasoconstriction of the subcutaneous arteries and larger arterioles associated with a vasodilation of the superficial minute vessels.

Having observed the vasodilator action of nicotinic acid, the author decided to use it in the treatment of the cold congested hands and noses from which so many young children suffer in the winter; the results were dramatic. The basic dose of nicotinic acid administered was for an adult 50 mgm. and for a child 25 mgm. thrice daily immediately after meals; this tended to reduce the incidence of flushing and caused a prolongation of the vasodilator action of the nicotinic acid. In severe cases the dose was increased, but in no case was it found necessary to give more than 300 mgm. a day. Relapse was common when the nicotinic acid was withdrawn. It is suggested that nicotinic acid is the method of choice in general practice owing to its ease of administration and its freedom from serious untoward effects.

Community Aspects of Care and Control of Pneumonia in Children

MARGARET E. HART, M.A.

THE PROTECTION of children from pneumonia is still a major public health problem. Pneumonia continues to exact a high toll of lives among infants and young children. It is still a leading cause of death in children of school age.

Means of providing passive immunity to pneumonia have not been found. Active immunity is short-lived and, therefore, impossible to achieve on a public health scale.

The causative agent is found at some time each year in almost every person's mouth. This adds to the difficulties of prevention.

Environmental sanitation does not appear to affect the incidence of primary pneumonia although it may be a contributing factor in the development of pneumonia as a complication of communicable disease.

To attack this major public health problem, the public health nurse must first know its extent in the district she serves. She must discover early children who develop pneumonia and she must be able to use her nursing and teaching skill in the care of these children.

INCIDENCE

Pneumonia remains close to the top of the list of causes of death in children. The number of deaths is highest in the first year of life. The Metropolitan Life Insurance Company has compiled figures showing a decline in deaths from pneumonia among children of school age in the past fifteen years. This reduction is approximately 78 per cent among girls 5 to 14 years of age and 68 per cent among boys in the same age group. A study of deaths from pneumonia in Manitoba from 1942 to 1946 shows a gradual decline in the number occurring in infants and children of preschool age. But the figures are still much too large. As a leading cause of death in children, pneumonia commands the attention of the entire community for its control.

Pneumonia, as a cause of illness, is not well reported, so that it is impossible to show the incidence of pneumonia in children or to make any reliable comparison of cases to deaths. Observations indicate that early recognition of symptoms with immediate and adequate medical treatment and nursing care are of utmost importance in preventing deaths from pneumonia.

PUBLIC HEALTH NURSE'S ROLE

The public health nurse must apply what she knows about pneumonia, its cause, and contributing factors as well as its mode of transmission, if she is to take an effective part in its care and control.

There is at the present time no one drug or mode of treatment for all infections. A specific etiologic diagnosis must be made before specific treatment may be prescribed. This makes it increasingly important that cultures be taken of discharges from the nose and throat of the sick child. The public health nurse may be instructed by the physician to collect and prepare specimens for laboratory examination. For example, Friedlander's pneumonia in infancy has been successfully attacked by streptomycin, whereas the sulfonamides and penicillin have failed in this specific disease. Again, rheumatic pulmonary lesions are considered by an increasing number of doctors to be specific, possibly allergic reactions. If this is

Miss Hart, who is presently director of the school of nursing of the University of Manitoba, was formerly educational supervisor with the Manitoba Department of Health and Public Welfare.

so, the therapeutic treatment in rheumatic fever will change. Children who have a history of rheumatic fever may develop pneumonitis some time after the endocarditis has subsided. Therefore, rheumatic fever is significant in the history of children with pneumonia which does not respond to the sulfonamides and penicillin. The public health nurse must know enough about the various causes of pneumonia to be able to make intelligent observations of the patient's condition and response to treatment in order to report her observations immediately to the child's doctor. This is particularly essential in rural areas, where the doctor is dependent upon the nurse and the family to keep him well informed of any significant developments.

Respiratory Infections

Infants and young children are highly susceptible to respiratory infections, including the acute communicable diseases. These infections are serious in this age group, with a relatively high rate of complications and deaths. Therefore, the public health nurse includes in her teaching of the mother the prevention of respiratory infection in the infant and preschool child. This teaching is begun during the prenatal period and continued through the child's early life. The infant should be protected from anyone with a respiratory infection. The mother must wash her hands before handling the infant or his feeding and other equipment. The feeding of the infant and young child is important and must include the protective elements, such as minerals and vitamins in adequate amounts. Sufficient rest, fresh air, and exercise are essential to the health of the infant. The public health nurse teaches the mother the hazards to the infant of aspirating oil or powder when the bath is being given.

Preventing Other Infections

The infant should be immunized against whooping cough in the first few months of life. This immunization should be reinforced as necessary, until the child is old enough to be able to make a successful recovery from whooping cough. The death rate from whooping cough and its complication of pneumonia is highest in infants, with almost all deaths due to whooping cough occurring in children under three to four years of age. It is imperative to protect infants and small children from exposure to other children who have whooping cough. This may be difficult or impossible if there is whooping cough in the home. If the infant or child under two years of age shows signs of pertussis, he should see a doctor at once. If the child remains at home, the public health nurse should teach the family how to provide continuous nursing care. The infant who is ill should never be left alone.

Measles in infants and children under two years of age is responsible for a high death rate. Measles may be complicated by pneumonia in this age group, so that prevention of measles affects the pneumonia case and death rate in this age group. Among Indian babies, pneumonia and measles combine to cause many deaths. There is now a means of conferring passive immunity for a short period of time, or lessening the severity of measles, by the use of immune globulin or gamma globulin in the case of infants, very young children, and debilitated children who have been exposed. Passive immunity is lost in a few weeks. Gamma globulin has been found to lessen the severity of the disease, giving a much better chance of an uncomplicated recovery. At the same time, by having the disease, the child has established a lasting immunity to measles.

Influenza is another respiratory disease, difficult to diagnose, which may be complicated by pneumonia.

Caring for Child at Home

The public health nurse teaches the mother how to recognize the beginning signs of illness and emphasizes the need for immediate medical service. She advises the mother to call upon her immediately, if the infant becomes ill, when her nursing visit

can be most effective. The nurse observes the appearance and color of the child, the nature of his breathing, his temperature and pulse and respirations, and passes on her observations to the doctor.

The public health nurse may be called upon to help the family arrange for hospital care. She gives nursing care in the home, when this is needed, and shows the mother or some other member of the family how to give interim care. She administers chemotherapy and other treatment as required under medical direction. She recognizes and teaches the family the significance of untoward reactions.

Nursing care is based upon absolute and complete rest. It may require all the ingenuity the nurse possesses to help the family achieve this rest for the sick child. The suggestions, included in this article, for the home nursing care of the child with pneumonia have grown out of discussions with public health nurses at work in rural areas.

The public health nurse should take time, on her first visit, to become acquainted with the sick child, giving her a chance to gain his confidence before she begins any treatment. Children need preparation for treatment and nursing care. The public health nurse should phrase her sentences very carefully in talking to children, so that they will understand what is expected of them. Children will respond well, even at an early age, when their need for rest and treatment is explained.

The child with pneumonia needs continuous nursing care. The public health nurse can help the family to arrange for this. If possible, she should plan to visit the home twice a day at first, then daily. In rural areas, it may be impossible for her to provide such constant care and very careful planning may be necessary in order to space visits most effectively. On the first visit to the home, the nurse may demonstrate the giving of nursing care to the mother or attendant. She would do well to return the next day, in order to give further help if necessary, and again in a few days to encourage continued bed care. Whatever the nursing service in the community, the family is left to care for the patient over the greater part of the day and emphasis must be placed upon the need for continuous and constant nursing care. Parents are most receptive to the nurse's teaching at this time, when they are most in need.

The attendant should be shown how to give the necessary care and treatment with a minimum of exertion for the patient. The child should be disturbed only for essential care, including nourishment, proper elimination, and administration of prescribed treatments. Chemotherapy reduces the temperature, preventing great loss of weight. However, the disease runs its course despite this and it may be even more difficult to ensure rest for a child who may appear and feel fairly well.

Make a game of nursing care for the small child, to reduce his exertion and secure his interest. To make the child more comfortable in bed, the rubber sheet should be well protected by covering it with a pad as well as a sheet. Soap should be mild and used very sparingly for the sponge bath. Bed linen and clothing should be laundered with mild soap and carefully rinsed in soft water, no bleach being used. This will help to prevent chafing of knees and elbows. Light, warm bed covering should be used. The patient should be kept comfortably warm, with the room fresh and cool, but not cold. Flannelette pyjamas with long sleeves will help to keep the child warm, especially when he is propped up in bed. He may need to wear a sweater to cover his chest.

The child should cover his mouth and nose with tissue or washed cotton squares when he coughs. A paper bag, pinned to the side of the bed, within easy reach of the child will enable him to dispose of these. The bag may be burned without unnecessary handling of infected articles. Dishes should be boiled, or washed in hot soapy water and rinsed in very hot water.

The child needs very careful attention so that his needs may be antici-

pated and his condition carefully noted, but he should not be disturbed by talking to or fussing over him. The sick child should be protected from exposure to any other infection and for this reason, as well as to secure rest, visitors should be kept away.

A sick infant should never be left alone in a room. Provision should be made for someone to watch him in order to observe his breathing and to be able to make breathing and coughing easier. The child should be held part of the time, to give him a feeling of security and love as well as a change of position. The baby's crib could be pulled into the parents' room at night.

The mother should arrange to spend as much time as possible with the child with pneumonia, so that he will not need to demand attention. This will prevent fretting and conserve his energy. He is less likely to establish a habit of getting attention which may carry over after he has recovered from his illness. To add to the older child's feeling of security, a bell should be placed within easy reach so that he is able to call for help when he needs it. A bell may be improvised with a glass and a spoon, or a spoon tied with string to the bed. A light should be provided, if possible. A long cord on the light, a bed-lamp, or a flash-light under the pillow will do. The child's bed may be placed so that he is able to see out of the window without facing it. Especially when he feels a little better this will relieve the monotony of lying in bed. Pictures which could be changed will add interest to the child's day.

The sick child should be fed to conserve his energy. The baby is always held in a semi-recumbent position when being fed. It may be necessary to use a medicine dropper for the bottle-fed baby who becomes exhausted and has difficulty in sucking. He must be fed frequently in small amounts. Seriously ill infants have gained weight on this kind of feeding. The older child will be able to take fluids more easily through a drinking tube or straw. His head should be raised and supported to enable him to swallow more easily. Small helpings of well-prepared foods which are light and easily digested will stimulate appetite. Calories may be added by sweetening fluids. Honey is easily dissolved and adds flavor to the child's drink. Gelatin or a synthetic protein may be used with added sweetening and citrus fruit juices.

When the child is able to eat alone, a bed-table will help to save his energy; this may be made from an apple box which has been papered. An ironing-board between two chairs will serve the same purpose. Snacks between meals will help to provide enough calories in the daily diet.

Singing is restful to babies and small children, and mothers will find that they may drop off to sleep with this attention. Reading to children enables them to lie quietly for a time. Toys hung on a string fastened across the baby's crib, so that they may be easily reached, will keep him quietly amused without causing undue exertion. This prevents his toys from dropping out of reach. It also prevents the anger and crying which results when the baby does lose his toys.

The older child will enjoy having a small radio near him. An apron with deep pockets for his play-things could be made to fit across his bed. This would enable him to reach his toys easily and would provide a safe place for them when he has finished using them. With the older child, it is important to keep him from reaching for things he has dropped on the floor.

Children, who are convalescing, need a period of rest morning and afternoon. The child's understanding of his need for rest will help him to settle down quietly, without undue argument. Children's activities, during convalescence, should be carefully supervised. A small piece of knitting or sewing that is light in weight will help to keep older children occupied. If the child is allowed to do school work to keep him from getting too far behind in school, this should be well supervised to prevent fatigue. A variety of activities is necessary to hold the child's interest and forestall boredom.

When children are allowed to sit up

in bed, they should wear a sweater or other warm covering for the upper part of the body. Very small children may be dressed so that it is unnecessary to disturb their play to cover them with bed-clothes. When the child is allowed out of bed he should wear a warm garment. In rural areas, provision must be made for the child to go to the toilet indoors for a long time after his recovery from pneumonia, if the weather is cold or inclement.

The child should be relieved as much as possible of physical and emotional strain during his illness and his activity should be carefully graduated during convalescence to avoid fatigue.

The public health nurse helps the family to secure the follow-up chest x-ray. Even in isolated areas, this may be achieved by careful planning. The travelling chest clinic provides one opportunity for such service.

Sharing Responsibility

Care of other members of the family and of the mother or attendant of the sick child are important during an illness which is as exacting as pneumonia. Usually it is the mother who accepts responsibility for nursing care of the sick child. She is exposed to infection and may be getting very little sleep, especially in the early stage of the illness. She will need adequate meals as well as an opportunity for small diversions from the sick room. She should try to get out in the fresh air for a short time each day. Each member of the family could share in the household duties, so that the mother would be relieved of extra work. Children might accept more responsibility for their own personal care.

Care of sickness in the rural home is often a neighborhood project. Neighbors may bring in food for the family. They may help with the laundry and housekeeping. Smaller children may be invited to visit the neighbors during the day. This allows them to play and make all the noise they like, relieving their feeling of suppression.

Case Study

The following family study illustrates some of the essential aspects of public health nursing service in the care of pneumonia:

A public health nurse in a rural area had planned a day's visiting in an isolated corner of her district. She had one request for a home visit and used this visit as a springboard to discover other public health nursing needs in that community. She was particularly concerned about the infants, young children, and those who were sick. She discovered, through questioning the first family visited, that there was an infant living a few miles away who was thought to be ill. Upon visiting this home, the nurse found a sick baby, five months of age, lying on a pillow on the kitchen table. The mother was quite worried about the condition of the child and had brought him into the kitchen where she could watch him carefully while she worked. If she had to leave the room, one of the other eight children kept watch over the baby. She said that the child had been ill about two days. The rectal temperature was 102°, the child was waxy in color and had a grunting cry and dry cough. The nostrils were dilated and the abdomen was tense. The baby had vomited his feedings. His buttocks were excoriated.

The public health nurse explained to the mother the urgent need for medical care. There was no doctor in the district and the nearest available medical service was in the city hospital. The father was working away from home and would not return until the next day, so the mother would make no decision until her husband returned.

Meanwhile, the public health nurse showed the mother how to give the baby a sponge bath and to care for the buttocks. She explained the need to give sweetened water frequently and how to hold the baby in her arms so that swallowing would be easy. The fluid was retained, no vomiting recurred. The head of the baby's bed was elevated so that he could breathe more comfortably.

Immediately, on the father's return home next day, the parents took the baby to hospital. A diagnosis of pneumonia was made and he was admitted for ten days, making an uneventful recovery.

The good relationships established in this home at the time of the baby's illness enabled the public health nurse to do effective health teaching with the whole family. The mother

and father get word to her now whenever they need her services. There are many evidences of learning on the part of this family. Even under economic handicaps, the diet has been improved. More careful selection of foods is made so that essentials are provided. They have become more conscious of the significance of good sanitation. Windows and doors have been screened, drinking water and milk are boiled for the children under two years of age. The children are given cod liver oil and citrus fruits regularly. The mother and father are doing their best to maintain the good health of their children.

The above illustration shows how neighbors assisted the public health nurse in case-finding. It also shows the results of early recognition of probable pneumonia. In this case, the mother knew that her baby was ill and she was giving him care to the best of her knowledge, but she did not know how to seek and use the available public health nursing service. The nurse sought her out at a time when she realized she needed help. Together, the public health nurse and the mother worked out ways of giving good nursing care with equipment available in the home, until the necessary family arrangements could be made to take the baby to the hospital.

Medical treatment and nursing care to minimize the dangers of pneumonia are essential for its control. The public health nurse must help families to secure care as early as possible.

The nurse will be aware of epidemics and cases of measles, whooping cough, and other illnesses which may be complicated by pneumonia. She must be particularly vigilant during the seasons and years when such illnesses are prevalent. Infants and young children in families where there are respiratory infections will require her especial attention. Teaching the mothers may be effectively reinforced at such times.

Community understanding, interest and action must be secured so that adequate services may be provided for the care and control of pneumonia. The public health nurse must know the needs in her community in order to promote such understanding.

REFERENCES

1. Anderson, G. and Arnstein, M. Communicable Disease Control. The Macmillan Co. of Canada Ltd., Toronto. 1942.
2. *Health Bulletin for Teachers.* Vol. XIX, No. 1, Oct. 1947. Metropolitan Life Insurance Co., Ottawa.
3. Miller *et al.* Friedlander's Pneumonia in Infancy. *J. of Ped.*, Nov. 1947, p. 527.
4. Mossberger, Joseph I. Rheumatic Pneumonia. *J. of Ped.*, Feb. 1947, p. 113.
5. *Public Health Nursing Curriculum Guide.* National Organization for Public Health Nursing, New York. 1942.

℞ *Chuckles* P.R.N.

When the doctor asked the patient if he wanted a local anesthetic, the reply was, "If the local is going to hurt, run me through on a sleeper."

In acute gall bladder attacks, the patient vomits and vomits in a vicious circle.

The enema was effectual, the patient expelling a large flatus.

When an infant is born it should be checked immediately to see if it has all the facilities.

Iron plastules should be taken through a straw.

Supervisor: I cannot understand why you have not found an opportunity to comb a patient's hair yet! You have been on this ward a whole week!

Earnest student: It isn't my fault! All the patients on Men's Medical just now are baldheaded.

An antigen is a protein serum used in cases of allergy.

A toxin is an injurious gas thrown off by bacteria.

A normal erythrocyte count is 16.6 per 100 cc.

Quarantine is the longest known incubation period.

Diaphoresis is inflammation of the diaphragm.

Seen from the Information Desk

DORA DEANE

TING-A-LING-LING! — The telephone! "Hello! Yes. Who did you say? Oh—the hospital. Yes? Could I help you out for a few weeks in the office? Well, I've never worked in a hospital; I know nothing about hospital routine. Well—if you need help as badly as that I could come for a short time before I leave for another job. Yes—all right I'll be there tomorrow at 8:30." And so began my month's work in the hospital of a small town.

I had worked in many offices during my business career, but this was my first experience of any kind on the inside of a hospital and I wondered what it would be like. This one was small with a capacity of one hundred beds, and during these days of staff problems it was short of help. It was filled to more than capacity, with beds out in the corridors. Moreover, they had been without a matron for some months.

I commenced my duties at 8:30 the next morning, after being introduced to the staff with whom I would work by the superintendent. To my surprise, instead of working in the office I was installed at the Information Desk, across the corridor from the Admitting Desk, just inside the main entrance.

The first task of the day was to enter up the Daily Charge Book. Ye gods! What a book! There were yards of it! On one side, the "patient days" were entered, that is, in columns headed for each day of the month a stroke was placed against the name of the patient occupying a particular bed. On discharge these strokes were totalled and the number of days charged to the patient. On the opposite page were the patients' names and numbers and numerous columns, all with different headings for the various charges—such as room rate, medicines, special treatments, radiology, etc.

We proceeded to the work of the day by entering admissions for the previous day. Ping-a-ling, ping-a-ling! The telephone! Taking the receiver off its hook, the nurse instructing me answered "Hospital. Just a moment, Mr. Jones. I'll consult the list."

"Mr. Jones wants to know how his wife and baby are this morning."

We consult the "condition list" which is prepared each day. "Hello, Mr. Jones. Yes. Your wife had a good night and the baby is fine."

We proceed once more and succeed in writing down one name. Ping-a-ling, ping-a-ling! The phone again! What is it this time?

"Dr. B speaking." Have we a bed for Mrs. A coming in from the country? Again we consult our list. No, nothing. What shall we do? Phone the floor. We do so. Mrs. C is going home later in the day we find, so we hasten to tell Dr. B that Mrs. A, his patient, can have Mrs. C's bed. Down comes Mrs. C's chart and we proceed to make out her bill. What are all these papers we have to consult? Admission sheet; discharge sheet; nurses' notes; lab. report; x-ray report; doctor's orders, etc. etc. etc.! We consult. We open the bill book. We enter the number of days and the rate. Simple! But is it? Not so fast! There are two columns — "amount payable" and "insurance." You see there is a hospital insurance scheme and those who are insured have their bills met from the insurance fund. Simple again! "Oh no! Certain items are not covered by insurance, Miss Brown. For instance—public ward—yes; a private room—no." Well—this is a private room so down it goes under "amount payable." "Oh no, Miss Brown! You see the patient only pays the difference between public ward and private room." By this time, Miss Brown has a buzzing in the head.

Ping-a-ling, ping-a-ling! That . . . phone again! "Hospital speaking." "What are the visiting days?" — we give the information. Once more we

proceed, and search through the chart to find how many doses of medicine are chargeable. Down they go in the insurance column.

"No, Miss Brown—that will not do. You see the patient had some penicillin, as well as some mineral oil, aspirin, and various other drugs. The penicillin is not covered by insurance, at least only 50 per cent is, so that must go in the other column. And these mustard plasters—well, you charge half of them to insurance also, and the same with x-ray (and one or two other items)."

Ping-a-ling! "You answer that Miss Brown." Miss Brown takes the phone —"Hospital speaking. Yes, doctor. What was that? Oh. You want to book an operation. What do I do, nurse?" "Consult the daily chart for the operating-room." The chart is consulted. "Yes, doctor. There is room on the 20th at 8:30 a.m. What is the operation? Teesanayes?" What on earth is that? thinks Miss Brown. However, she writes it down together with the name of the patient and the kind of anesthetic to be given. Later she learns that "Teesanayes" are "Tonsil and adenoids" or "T's and A's." Live and learn!

Once more we go back to our bill, and by this time Mrs. C has come to the desk for discharge and we must phone for a taxi, present her bill, and endeavor to collect the portion payable . . . Well, that is accomplished . . . we go back to the charge book. Where were we? By this time half a dozen people, including various nurses, have visited the desk and all our papers are scattered—our pen has disappeared, also our scratch pad! We search for them and find them on the admitting desk on the other side of the corridor. Evidently they have wings! We tidy the desk and proceed. We enter the name and number but the admission sheet has disappeared. Ah! Here it is on the floor. The entry is made and with several more interruptions we finally complete the charge book for the day, which by the way has to balance with the census book from each floor, but *will* it? These census books are entered at midnight each day showing the names of the patients in each bed. By this time, believe it or not, four hours have passed and it is lunch time. Miss Brown departs to renew her energy for the afternoon's frav.

Refreshed from lunch, Miss Brown returns wondering what is next on the program. Oh! It is visitors' dav. From 2-4:00 and 7-9:00 p.m. patients in public wards may receive friends and relatives on three days during the week. Those in private rooms may see them each day. Miss Brown settles down to tvpe a few letters and send out a few accounts. Beside her on the desk is the list of patients and the wards and rooms which thev inhabit. It is the duty of the clerk at the desk to see that not more than three visitors are with a patient at one time. Well that should be easv, she thinks. Poor deluded woman! Little did she realize that she would need eves in the back of her head and the feet of a centipede to cope with the situation. For a time all was well. The door would open and a meek voice would ask, "Mav I see Mrs. So-and-So, nurse?" "Certainly," replies Miss Brown. "Room No. 323 on the third floor—straight through the door and upstairs." Back she goes to her typewriter and puts in a sheet of paper. By this time two more visitors are waiting. "Miss Smith? Straight along that corridor, Room No. 5," and Miss Brown puts a tick against the name of the patient receiving the visitor and notices that one other is already in the ward. By the time she looks up again half a dozen more are at the desk and out of the corner of her eye she notices a stray figure stealing up the corridor. Leaving the other six she dashes off after this "stray lamb" just in time to prevent him from entering a room which has its full complement of visitors. Back she takes him to the waiting-room to stay until one or other of the three have completed their stay. By this time the six who were waiting have disappeared and there are at least a dozen more. Thick and fast they come! She looks at her list and tries to figure out who has visitors and who has not but her

mind is in a whirl. The whole hospital seems alive and resounds to the tramp of feet as visitors come and go. How could one lone female hope to battle against such a multitude? She sits back and decides to let them have their way and to take in the spectacle and enjoy a well-earned rest.

Looking around she spies one patient, a fair young thing in her teens, who has descended to the waiting-room and is holding a reception—apparently composed of her girl and boy friends—mostly boy. Peals of laughter come down the corridor. Miss Brown endeavors to quiet them—she might as well save her breath! However, she finally succeeds in persuading the majority to depart and the patient returns to her room. Incidentally the patient is almost due for discharge so no harm results.

This reception is followed by another of a different type. A Japanese is visited by his family, including his sisters and his cousins and his aunts. There is much bowing and smiling and laughter. Everything appears to be taken as a great joke. While this is going on a nervous young man approaches the desk. Twisting his hat in his hands he says, "May I go up to see my wife, nurse, please?" Miss Brown, by the way, is not a nurse but the public appears to think she is. She smiles at the young man. "I'm sure you must get fed up with us amateur fathers," he continues, giving himself away. Up he goes with eager steps to visit his wife and their first baby. Later, on his way out, he stops again at the desk and solemnly remarks, "I've decided not to take them home, nurse." "Oh!" says Miss B, "and why is that?" "Well I must admit," says he, "that I've seen better looking children. This one has no teeth; its eyes are shut and it has bow legs. If my wife can't do better than that—well!" Miss Brown decides he is not such an "amateur" after all!

The afternoon has passed and there is a steady exodus of visitors until all is peace once more.

Of course there is the tragic side too. The occasional death; the report showing that a patient's condition is hopeless; the x-ray and lab. reports showing clear indications of disease; the anxious relatives making inquiries, always hopeful and praying that some miracle will happen and the patient will pull through. These, Miss Brown found to her relief, were very much in the minority. The majority of patients went home, improved if not cured. While at the desk she watched many happy reunions between patients and relatives.

"Improved or cured!" Oh yes! One of Miss Brown's duties, she found, was to make out numerous and various forms for the government and other organizations. On one of these forms the "diagnosis of patient's disease" was entered in one column and the result "improved" or "cured" in the next. Upon filling in one report Miss Brown found this: diagnosis—in labor —result . . . cured. Well, she thought, what does that mean exactly? In fact she found herself in a state of amazement from time to time. One morning on checking reports from the maternity floor, reports which recorded the births during the night, she found— "Born to Mrs. So-and-so at 3:00 a.m., apparently a male." "Good heavens," stuttered Miss B, "what can this mean?" and taking the report she called upon the nurse who had submitted it for an explanation. Much to her relief she found that the word "normal" had been omitted before the word "male!" All was then clear, that being the accepted wording.

Each day patients requiring x-rays would come down to the x-ray room. Those unable to walk came in wheel chairs. One day Miss Brown noticed a nurse approaching wheeling a chair. Thinking it was a patient on the way to x-ray she looked up and smiled but her smile quickly changed to laughter for, believe it or not, no patient occupied the wheel chair. It was piled high with rolls of toilet paper! The nurse in charge of drugs and supplies was making her rounds!

Every Sunday one member of the office staff remained on duty at the admitting desk throughout the day. It was Miss Brown's turn three or

four days after she commenced her duties. She arrived with feelings of trepidation. She knew so little and hoped and prayed it would be a peaceful, uneventful day, if there were such a thing. Vain hope! The hospital was full to capacity. The phone kept up a constant ring all day. One emergency on top of another. Doctors to be called; children hit with baseball bats, with swellings like eggs on their heads; broken legs; poisoned hands, etc. etc. etc. Fortunately most could be treated as out-patients. However, during the afternoon, on answering the phone she heard Dr. R on the line. "Oh, Miss Brown. I want a bed at once for Mrs. T." "I'm awfully sorry, doctor —there is not a bed anywhere in the whole hospital according to our list." "One will have to be found, Miss Brown. I am sending the woman in immediately." "What is wrong with her, doctor?" "A miscarriage" — the doctor replies.

Miss Brown nearly dropped the phone. This was something which had never confronted her before and about which she knew nothing. Hanging up the receiver she dashed up to the maternity floor, only to find that such cases were not admitted to that floor. Up to the third floor, there to find by some miracle there was a bed. How she blessed the nurse who was able to solve the problem! Back to the desk to await the patient. What should she do when she arrived? How would she get her up to the floor? *Would* she get her up in time? If not, what would she do? By the time the patient arrived Miss Brown herself was ready for admission. Finally, Mrs. T walked in from the waiting taxi—perfectly calm and collected. Miss Brown, still nervous, decided to take no chances and escorted her to the floor immediately, leaving the nurse in charge to make out the many and varied forms necessary to complete the hospital records. By this time it was five o'clock and, with a sigh of relief and feeling completely limp, Miss Brown departed for home.

And so it went, from day to day. Interesting, human, sad, tragic, amusing, inspiring—the life in one of our smaller Canadian hospitals, staffed with sympathetic, hard-working nurses, endeavoring to carry on and give service under trying, over-crowded conditions; doing their best until such time as conditions return to normal and relief comes to them, as to others in any walk of life which serves the health and welfare of our people.

Sunnybrook

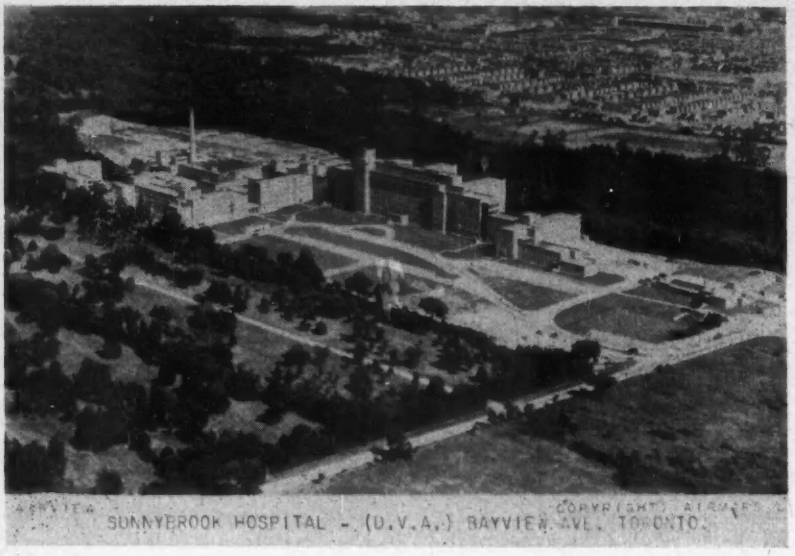
C. A. Pope

THE CONSTRUCTION and development of Sunnybrook Hospital, the Department of Veterans Affairs' largest and most modern healing centre, have been followed with interest by members of Canada's nursing profession from coast to coast. The huge 1,450-bed institution at Toronto is now nearing completion with a patient strength already in excess of six hundred.

Officially opened last June by Prime Minister W. L. Mackenzie King, Sunnybrook is ideally located amidst five hundred acres of rolling countryside just outside the city. Canada's most impressive memorial to members of the services who died for their country, the hospital is fast becoming known internationally for its high treatment standards.

Although built primarily to service veterans from the densely populated Toronto area, patients transferred from other D.V.A. hospitals are benefitting daily from the ultra-modern treatment facilities at Sunnybrook.

Mr. Pope is regional public relations officer with the D.V.A. in Toronto.



Completed are the neuro-psychiatric, up-patients' and active-treatment blocks. The out-patients' wing is expected to be ready for operation in the near future. Other hospital features in daily use for some time now are an 800-seat auditorium, the maintenance building, the Red Cross Lodge and, of course, the power plant, the first department to be constructed.

Nearing completion are the nurses' and staff residences, the administration wing, and the prosthetic services' factory. A pulmonary building, gymnasium, swimming-pool, and chapel have yet to be started. To date, approximately $16,000,000 have been spent on Canada's largest general hospital.

Readers of *The Canadian Nurse* will be particularly interested in the Sunnybrook nurses' residence, now in an advanced stage of construction. Located at the northeast end of the grounds, this U-shaped building will contain a basement and four floors. In addition to approximately three hundred bedrooms, each including a large clothes-closet and bathroom, the residence will contain numerous living and reception rooms. Massive fireplaces in several of the living-rooms add to the attractiveness.

All floors contain kitchenettes and laundry facilities and other features will be spacious sun-rooms, similar to the 40-odd located on the south side of the main hospital buildings. On the north and west sides of the top floor are being constructed large sun decks. These are expected to be particularly popular during the summer months.

The main basement will contain racks for the storage of trunks, rooms for clean and soiled linen and equipment accommodation, as well as a maids' locker-room. Here also will be a large garage. On the ground floor, attractive waiting-rooms for visitors of both sexes are under construction and batteries of public telephone booths will be placed nearby to provide adequate service for the nurses and their friends.

Nurses now employed at Sunnybrook Hospital are nearing the 200-mark of whom about a quarter saw service during the recent war. The nursing staff will total about three hundred when the hospital is completed and in full operation. Those deciding to remain in residence expect to move into their new quarters next spring.

The hospital matron is Miss Frances Charlton, a graduate of the Toronto General Hospital, who served with distinction during World War II.

Appointed matron of Sunnybrook Hospital in May, 1946, Miss Charlton has played a major role in the development of the new veterans' institution. With the hospital superintendent, Dr. K. E. Hollis, she has helped to guide the destinies of the largest link in the D.V.A.'s chain of thirty-three healing centres.

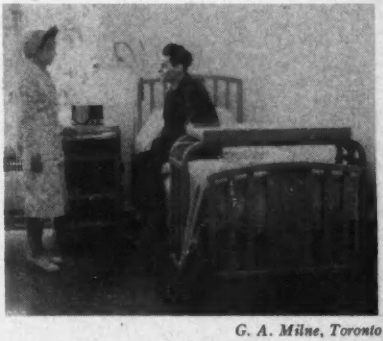
Wards at Sunnybrook vary from the private type to 24-bed units. The latter are subdivided into six sections, each containing four beds. Pleasing pastel shades and attractive drapes add to all wards a "homey" atmosphere, uncommon in most hospitals.

Each ward floor contains a servery for the preparation of light meals as well as a small dining-room for up-patients unable to walk to the main cafeteria on the ground floor. Food is transported from the main kitchen to bed-patients on electrically heated trolleys so that those confined to bed enjoy the same freshly cooked meals as are served in the cafeteria.

A focal point of entertainment for patients and staff alike is the Mackenzie auditorium. The nest-type seats may be stored beneath the stage to clear the floor for dancing. Two standard projectors provide popular films and the huge stage, with the latest lighting facilities, is equipped for every type of production.

Besides standing out as an active treatment hospital, Sunnybrook is already making a name for itself as a teaching institution. Toronto's leading specialists have made themselves available as consultants. They direct the activities of staff physicians and internes.

A wide tunnel, just a few feet short of half a mile, connects the power plant at the east end of the grounds with the Red Cross Lodge at the west. Patients and staff can thus move to and from the various units



G. A. Milne, Toronto

Typical private ward at Sunnybrook Hospital. Note burn-proof overbed table which can be used by bed patients for shaving or reading table. Every patient has own individual radio whether in private or 24-bed ward.

of the hospital without leaving shelter. An offshoot of the tunnel leads to the nurses' residence.

A handsomely appointed branch of the Toronto Public Library makes available to patients and staff the city-wide facilities of this metropolitan service. A sub-district post office, similar to those serving Canadian communities of three thousand, has been in constant use for some months.

Occupational and physiotherapy departments, specially designed for the hospital, contain the latest and most up-to-date installations. The operating theatres are the finest in Canada and all are completely explosion proof.

Already Sunnybrook Hospital's arthritic clinic has emerged as Canada's largest and most modern. A continuing program of research is providing valuable information which is exchanged with similar clinics scattered throughout the world.

Entertainment for the patients, besides that provided in the hospital auditorium, includes both alley and lawn bowling. Last summer an attractive miniature golf course was opened and patients take part in a variety of other outdoor games and sports. Various individuals and organizations interested in hospitalized veterans provide tickets to hockey, football and baseball games, boxing and wrestling matches, moving pictures, plays and concerts, and both automobile and bus trips to points of interest in southern Ontario.

When landscaping of the grounds is completed, Sunnybrook Hospital and its environs will be one of the show places of the Toronto area. With the institution's growing fame as a leading healing centre, this will combine to make Sunnybrook an outstanding temple of mercy and a lasting memorial to those who gave their lives for Canada during the past two wars.

A Nurse's Prayer

(The following lines are reprinted from *The Nursing Journal of India*, June, 1948.)

Because the day that stretches out for me
Is full of busy hours, I come to Thee
To ask Thee, Lord, that Thou wilt see me through
The many things that I may have to do.
Help me to make my beds the smoothest way,
Help me to make more tempting every tray,
Help me to sense when pains must have relief,
Help me to deal with those borne down with grief,
Help me of life to brighten up the gloom,
Help me to bring to every soul in fear
The sure and steadfast thought that Thou art near.
And if today, or if tonight, may be,
Some patient in my care sets out to sea
To face the great adventure we call death,
Sustain them, Father, in their parting breath.
Help me to live throughout the live-long day,
As one who loves Thee well, dear Lord, I pray.
And when the day is done and evening stars
Shine through the dark, above the sunset bars,
When weary quite, I turn to seek my rest,
Lord, may I truly know that I have done my best.

— RUTH WINANT WHEELER

Public Health Nursing

The Workshop as a Tool in Staff Education

HELEN GILL

INSPIRED by the success of the workshops at the C.N.A. biennial meeting in Sackville, members of the Nursing Counsellor Staff of the Civil Service Health Division, Department of National Health and Welfare, Ottawa, decided to try out the workshop method in their staff education program.

The nursing staff of the division consists of the chief supervisor of nurses, her assistant, and twenty-four nursing counsellors. There is also a supervisor of welfare services.

The nursing counsellors were divided into three study groups, each under the leadership of one of its members. The three supervisors were available as consultants. Each group elected one of its members as secretary. A topic for discussion was chosen for each workshop from material of general interest, the subjects selected being: "The Return-to-Work Interview," "Personnel Contacts," and "Technique and Procedures." Five sessions of approximately two hours each were spent in group discussion and three further general sessions were devoted to presentation of findings and recommendations.

THE RETURN-TO-WORK INTERVIEW

This is understood as an interview with the employee following any absence due to illness. The subject was discussed on the basis of the following questions:

1. Is the return-to-work interview really worth while, or is there danger of it becoming merely a rubber-stamp routine?
2. What is the value of these visits to the employee?
3. What is their value to the employer?
4. If they are valuable, how can we convince the employing departments of that fact?
5. What is a desirable technique for such interviews?

This workshop group was fortunate in having as visitors the director of the division, who interpreted the primary purposes of the return-to-work visit, and also our psychologist, who gave an instructive talk on some pertinent aspects of interviewing.

From the first this workshop produced most animated discussions and its members felt the time was all too short. In presenting their findings to the whole group, nine recommendations were put forward in regard to policies and procedures.

PERSONNEL CONTACTS AND HOW BEST TO RECORD THEM

The second workshop group discussed this subject which would be of interest in any industrial nursing set-up, but would necessarily vary with the type of organization.

The Civil Service Health Division is comparatively new in the field and the scope for interpreting the service to various government departments is enormous. Nursing counsellors are allocated to health units in approximately 11 buildings in Ottawa. Each of these units serves from 500 to 2,700 employees, who may come from as many as 20 different departments. This constitutes a very special and formidable problem in personnel relationships.

The topic of this workshop also stimulated very active discussion, and it was agreed that, considering vari-

Miss Gill is a member of the Nursing Counsellor staff of the Civil Service Health Division, stationed at Ottawa.

ations in departmental set-ups, and allowing for the human element, no one standard approach could be laid down. However, some general principles emerged:

1. That definite appointments for interviews should be made with departmental heads or personnel officers.
2. Records of such interviews should be kept.
3. Interpretation of health service should begin with this interview, bearing in mind that more than one interview is usually necessary to develop complete co-operation.
4. Blueprints of buildings and organizational charts of departments are desirable.

One session of the workshop dealt with methods of recording personnel interviews. The findings of this group were presented in the form of a symposium under four headings:

1. Type and value of personnel contacts.
2. The value of many of these contacts having been made at an administrative level prior to the opening of a new health unit.
3. Method of recording contacts as a basis for a unit history and monthly narrative report.
4. Statistical recording of personnel contacts on daily and monthly tally sheets.

General discussion followed each topic and it was agreed to submit to the administrative staff recommendations for the procedure to be followed prior to the opening of new units. Two members of the workshop gave an amusing skit dramatizing these recommendations.

Techniques and Procedures

In the third workshop the approach necessarily differed from the other two, the topic being rather more technical. It was hoped in this workshop to study actual conditions met, and treatments given in health units, with a view to standardizing procedures based on the Standing Orders, and to assemble the material in some form to serve as a guide or reference for present and future nursing counsellors.

As a basis for discussion three papers were prepared and read, describing actual cases seen for a period of one month in a given unit. Most valuable discussion followed from these papers; also many questions arose which it was felt should be clarified by the medical staff. Two of our doctors attended one session and were very helpful in answering questions about procedures.

A fairly detailed report of this workshop was presented to the whole group, and out of it came a small manual to serve as a reference guide on techniques and procedures. Another valuable outcome was a slight revision of our Standing Orders with a very detailed appendix on the first aid treatment of burns.

Values of this Method

At the conclusion of the workshops all who had taken part agreed that the time and effort involved had been well worthwhile and it was felt that the workshop method could be used to advantage by any group of nurses having an organized staff education program. Topics for discussion would necessarily differ, but the method would be essentially the same. Some of the values would seem to be:

1. That it develops potential qualities of leadership. Leadership of a small group accustoms the individual to formulating and expressing opinions lucidly and helps to develop skill in discussion.
2. It encourages new or junior members of the group to take part in discussion, gives them a feeling of belonging to the group and of responsibility for policies developed from findings. Differing backgrounds of experience of the members adds interest and variety to the discussion.
3. Policies, techniques, and skills, developed from the workshop discussions, have a particularly practical value since they are based on actual experiences peculiar to the group.

In conclusion, here are a few hints for the benefit of any group which may be considering a workshop program:

1. The size of the group is important. It should not be too large, but a certain per-

centage of absenteeism must be anticipated. In groups of less than twelve the absence of one or two members limits discussion and leaves too heavy an assignment on a few.

2. Too many sessions over too long a period tend to drag. Too much reviewing is necessary and the interest lessens. Once a week without breaks, or even oftener if practical from the standpoint of assignments to be prepared, would seem to be adequate. It is better to narrow the scope of the discussion than to allow it to go on for too long.

3. Group leaders need not be particularly expert in the subject being discussed, but should have some preliminary coaching in workshop techniques and in their role as leaders. At the first session the leader should explain to the group the procedure to be followed and the responsibility each member will have for the success of the workshop. There should be general agreement on the scope and direction of the discussions and allocation of assignments.

4. To lend purpose and impetus to the discussions there should be a definite plan for the implementation of findings, and the method of presentation of findings should be decided by the group.

5. It is important that accurate minutes of the sessions be kept, and mimeograph facilities, if available, are useful and time-saving.

6. Outside consultants are valuable but any introduction of administrative opinion discourages free discussion and may prejudice findings and their reception.

7. A prepared bibliography of available material is useful and may encourage further study.

As an indication of the success of workshops as a technique in our staff education program, further topics have already been suggested by the participants for another series at an early date.

Music Therapy in Hospital

Of all the arts, perhaps music is the one which demands the greatest concentration for its understanding. The poet magically strings together words which he has heard before, the painter subtly paints what he has seen or would like to see, but the musician writes music which has had no previous counterpart in nature and, therefore, requires enormous concentration for its understanding. Music, because it demands so much, gives the greatest release from external circumstance and it is only natural that it should be of the greatest psychological value towards the recovery of a patient.

The Council for Music in Hospitals came into being last November with a committee consisting of medical superintendents of mental hospitals. During 1947, more than twenty-four hospitals had concerts and musicians were most generous in giving their services for modest fees. Already the idea has aroused psychological interest and a sub-committee is researching into the results of these concerts. It is certain that music can exert beneficial influence in illness and can turn the patient's interest away from that often all too absorbing and worrying topic of interest — himself.

The performance of a piece of music appeals to the eye as well as the ear. There has to be muscular as well as mental control of the subject. Children with non-pulmonary tuberculosis in some of the sanatoria in Switzerland are taught to play on pipes and the actual physical performance must be a discipline that is well worth acquiring. In certain illnesses, as in some orthopedic complaints, and in many mental illnesses, the using of both mental and physical energy in the playing of a musical instrument would be of great value to the patient. The joy of making a dead piece of music live is a creative one, and whoever plays the instrument becomes an active and not a passive listener.

If music therapy in hospital can be developed into performance by the patient, it will, indeed, have become a valuable therapy.

— *Nursing Times*

Not until you can see the joke on yourself are you grown up. Not until you can laugh at that joke has your judgement reached maturity and your sense of justice been enthroned.

— *Selected*

Institutional Nursing

Are We Guiding or Are We Driving our Students?

SISTER MIRIAM DOLORES, F.C.S.P.

IN THE "dear, dead days," (not beyond recall), when schools of nursing were "training schools" and their directresses were called "superintendents," comparatively little thought was given to the all-important phase of student education programs. The patient was looked upon, and rightly so, as the most important person in the hospital, while all concerned worked together as best they could, under existing circumstances, to give him adequate care and restore him to health as soon as possible. Nurses were trained and educated as a group of fairly intelligent young women who had come to the institution to serve and relieve suffering humanity. The average supervisor initiated a class of new students to her department by showing them the location of the linen closet, bath water, and their patients. And head nurses were often heard to sigh, "Oh dear, a crowd of new probies!" There was little or no individuality about the nurse—her uniform was white, she wore a cap, and she took care of patients.

MODERN ATTITUDE TOWARD NURSING EDUCATION

Today, nursing education is taking on a much rosier hue. The student is recognized as a human being, an individual possessing spiritual, mental, and physical characteristics which make her a distinct unit. Her views are regarded attentively, her reactions considered, her background taken into consideration, aptitudes studied, social life provided for, and her religious beliefs respected. She is no longer just a part of the group; she is a very definite consideration of nursing educators, supervisors, and head nurses. And today student guidance — educational, vocational, and personal—is looked upon as a basic function of every educational program. Those who are closely concerned with schools of nursing are coming to know that "education," as John Ruskin puts it, "does not mean teaching people what they do not know . . . It is a painful, continual, difficult work, to be done by kindness, by watching, by warning, by precept and by praise—but above all, by example!"

Most of us have had occasion, sometime or other, to take courses in student guidance, personnel policies, or Training Within Industry programs. We thought, I am sure, that the material presented during these courses was exactly what we had been seeking, and we agreed whole-heartedly with the suggestions offered for better relationships between student and supervisor—or worker and employer. And we returned home, no doubt, laden with remarkable ideas, full of enthusiasm, plus some very good resolutions. But actually, what have we done about it? We who are nursing educators, supervisors, head nurses—are we guiding our students —or still driving them?

PUTTING RESOLUTIONS INTO PRACTICE

Let us take a look at ourselves, our programs and policies, our methods of

Sister Miriam Dolores, F.C.S.P., is on the staff of the Sacred Heart Hospital, Spokane, Wash.

handling the problems which confront us every day, our teaching in the classroom and on the wards—and let us see how much real help we are actually giving our students during the three years they spend under our care. Let us see if we are remembering and really putting into daily practice all the wonderful things we know about maintaining good personnel relationships. And if we are failing our students in this all-important duty of guiding and helping them, let us strike our breasts and take some practical resolutions!

It might be advantageous for us, while looking over our responsibilities, to review briefly the three types of personnel policies given by W. J. Dietz, associate director of the Training Within Industry program of the War Manpower Commission. In his *Workers Have Feelings*, he says:

> Personnel policies fall into three types: First, the ostrich type—head in the sand, neck stuck out, trusting that everything will blow over; second, the sleeping dog kind, with much pussy-footing around, hoping the dog won't wake up and, if he does, won't bite; and, third, the chanticleer type which has something to say and says so in a clear voice—the kind of policy which creates job satisfaction and better understanding between management and employee, that leads instead of bosses, that teaches instead of tells, that listens more and talks and argues less, that has more frankness and more diplomacy attached to it, that fosters trust instead of suspicion, understanding instead of logic, where there is more interpretation and less jumping at conclusions, and over all and through all, a spirit of friendliness.

In the light of these qualifications or divisions, what about *our* personnel policies—under which type could they be honestly classed? And, of equal importance, what about those of us whose job it is to maintain and execute those policies? Are we putting across the kind of policy, and in a way which really creates job satisfaction and better understanding between our students and ourselves? Are we doing anything to better ourselves as supervisors? Most of us realize that constant and expert supervision is the best known method for improving the quality of nursing and, with even a limited knowledge of young people, we realize that few students have the educational background or maturity to learn by themselves. They need help and guidance all along the way —*our* help and guidance! What are we doing for them?

Realization of Students' Problems

Today the average young woman who aspires to the nursing profession is in her adolescent years. She comes to the school of nursing direct from high school, and according to regulations must be from the upper third of her class. That means she is an average high school graduate; but what else do we know about her—with the exception of a few necessary recommendations from the principal, pastor, and friends? What is her general knowledge and background? Can she make fairly good decisions? What are her reactions to given circumstances? Does she know how to study and apply herself? Much of this information may be gleaned from the usual placement and achievement tests which are given to the pre-clinical student, but its worth is measured only by the intelligent use of such knowledge by the directress of nurses. That point is too frequently overlooked by many.

During the pre-clinical period, friendly, personal contacts between the student and her directress will prove to be a valuable means of future guidance in the crises which are inevitable during three years of training. And those discouraging days, consequent upon a life of intimate contacts with so many and such different personalities, will find a little ray of light and hope shining through the clouds if the student feels she has someone in whom she safely may seek help and find an understanding heart.

Ability to Inspire Confidence

So many times nurses are in awe of their supervisors and directresses, and this leads to an unhealthy attitude toward authority, an airing of diffi-

culties to those who cannot remedy them, and ofttimes a bad feeling among the group. Very often, the fault lies with us. Do we always seem to be in a hurry when someone comes to talk over her problems? Are we sympathetic, understanding, and gentle in our firmness—when firmness there needs to be? Do we take time to "get all the facts" and "weigh and decide" before we make those decisions which seem so unimportant to us, but which may have great influence upon someone's life or happiness? Does the student feel, always and everywhere, that we are being absolutely fair with her—that she is not discussed with others, that her secrets are guarded? If so there will be that splendid co-operation and mutual loyalty so necessary to efficient and effective schools of nursing.

Applying some of the principles of good teaching to supervision on the wards, let us consider for a moment our responsibilities as supervisors. The supervisor's first duty is to furnish and make available to the student the necessary tools for her work. That clinical experience may be available, but the average student does not know how to use it in order to get the most for her patient and for herself. In any situation the nurse will learn only if the supervisor gives her the necessary guidance. There must be planning on the part of the supervisor. In that regard, I like what Leland P. Bradford and Ronald Lippit say about the characteristics of a "democratic" leader in their booklet, *Building a Democratic Work Group:*

The democratic supervisor endeavors whenever possible to share with his group the decision making about work planning, assignment, and scheduling. Where there is a decision to be made by him, he helps the group to understand clearly the basis for his decision. He is careful to develop as much participation, opinion giving, and decision making as possible and a feeling of responsibility for the success of the work on the part of everyone.

METHODS OF A GOOD SUPERVISOR

The good supervisor suggests rather than commands, leads rather than dictates, praises rather than blames, and tries to interpret situations instead of making hasty decisions. Reliability, sincerity, and loyalty are priceless and necessary personal characteristics for anyone in a supervisory position. And no one dealing with students can be without patience, tact and, above all, a saving sense of humor in meeting successfully the many daily irritations.

Finally, a good leader must have a stimulating personality, for no one who thinks only of herself ever gets anywhere in this world. She must be vitally interested in others, and inspire confidence in every situation in which she is placed. Quietly and assuringly she sees that new activities and skills are built upon what the student has already learned, thus broadening and deepening her experiences.

Blood Tests of Hospital Patients

In the belief that routine blood testing for syphilis on all hospital patients would prove to be a worthwhile effort, the Social Hygiene Committee of the Health League of Canada suggests it might be advisable to ask the various provincial authorities to bear the financial costs involved in such testing.

A survey, recently completed by the Health League, reveals that only 20.97 per cent of Canadian hospitals replying to a questionnaire dealing with blood testing do routine tests on all patients admitted to hospital. Out of 553 hospitals polled, 453 replied to the questionnaire.

Twenty-three hospitals reported they did routine on all public ward patients only — 57 tested obstetric patients only — 23 did routine cord Wassermanns.

Eighty-seven of the 95 which reported routine tests on all patients also revealed the percentage of positive tests which turned up as a result. For instance, 27 reported positives were below 1 per cent, 30 stated they ranged between 1 and 2 per cent, 17 revealed 2 to 3 per cent were positive, while 13 reported their positives were over 3 per cent. One of Canada's largest hospitals reported that positives ranged around 7 per cent.

Private Duty Nursing

Shock

MARGARET A. STRANG

IN MEDICAL literature of the last thirty years the term "shock" has described a clinical picture, characterized either as a sharp fall in arterial blood pressure or as the signs and symptoms of a decrease in cardiac output. When a physician states a patient is "in shock" he is describing the general appearance of that patient. The term has no specific physiological connotation. It does not indicate why the circulation has failed. It simply implies that failure has occurred.

Shock, as we nurses understand it, is marked by pallor, clamminess of the skin, sweating, nausea, decreased blood pressure, feeble rapid pulse, decreased respirations, restlessness, cold extremities, anxiety, and sometimes unconsciousness.

Various authors, from time to time, have attempted to restrict the use of the term "shock" to circulatory insufficiency produced by a failure of venous return to the heart. Further work has convinced them that a physician, in many instances, cannot determine at once the physiological basis of the circulatory failure. He desires to describe in a word a clinical picture dominated by the signs and symptoms of circulatory insufficiency, without committing himself to the cause of circulatory failure. By common use, the word "shock" has become entrenched in this sense, and it does not seem wise or possible to change its meaning.

On theoretical grounds it is clear that the clinical picture called shock can be produced by failure of one of several portions of the circulation. It may arise from the inability of the heart to pump the normal amount of blood, caused by weakness of the heart itself, as in a patient with a rapid heart rate resulting from auricular tachycardia, ventricular tachycardia, or auricular flutter. Shock may also result from inability of the heart to fill properly, because of pericardial tamponade, as the result of a stab wound of the heart, or from rapidly-forming pericardial effusion, thus blocking the inflow to the heart. Blocking of the main arterial paths, as in pulmonary emboli, may cause the clinical syndrome known as shock. Hemorrhage produces shock by decreasing the volume of blood returning to the heart, thus making impossible an adequate output of blood from the heart. Acute infectious diseases cause generalized failure of cellular metabolism, which condition will cause shock. Loss of normal vasoconstriction tone produces shock. How much of the circulatory failure is caused by venous pooling in the veins, the tone of which has been decreased by disease or by drugs, and how much is the result of arteriolar vasodilation induced by the upright position, have never been demonstrated. It is possible that both mechanisms are important.[6]

Shock may be classified as: traumatic, surgical, and hemorrhagic.[4] Regardless of the type of shock, the actual pathological finding is loss of fluid from the blood vessels. Hemorrhagic shock results from the loss of whole blood; traumatic and surgical shock are caused by loss of the fluid part of the blood. This is the reason surgical shock causes hemoconcentration, characterized by increased hemoglobin and red cell count readings.

The measures to be employed in the treatment of shock have been recognized since World War I. These are—control of hemorrhage, when present; application of heat; replacement of lost fluids; relief of pain; administration of oxygen; and the restoration of circulatory blood volume.[3]

The necessity for the control of hemorrhage is obvious.

The application of heat to shocked patients has been performed excessively. The treatment of shock by reduction of general body temperature loss was originated in clinical observations begun in 1940 and first reported in 1942:

> The method is precisely opposite to the traditions of blankets, hot water bottles, and electric light cradles. The rationale is clear, namely the reduction of exudation, such as sweating, and probably of toxin formation; the more liberal supply to vital organs by constriction of superficial vessels; and especially the relief of anoxia by reduction of total metabolism.

Much fluid is lost by sweating, which external heat produces, thus causing the patient more fluid loss.

> Merely covering the patient sufficiently to prevent extensive heat loss from the body by radiation will be of much greater value.
>
> Clinical and experimental observations now leave no doubt that the difference between high and low environments on body temperature can amount to the difference between life and death in shock.[3]

Since shock results from loss of body fluids, our first consideration is the replenishing of these fluids with either blood, plasma, or saline. The agent to be used is determined by the physician, according to the cause of shock in a particular case. In shock due to hemorrhage the blood volume is brought up to normal with transfusions of whole blood, whereas, in surgical or traumatic shock, where there is hemoconcentration, whole blood is contraindicated. Here plasma is given intravenously to bring the volume of circulatory fluid up to normal.

> Human albumin is sometimes given as a substitute for plasma. It cannot replace whole blood, but its small bulk, the ease and rapidity of its administration, its stability at room temperature, and the absence of unfavorable reactions make it useful in many emergencies. Sometimes solutions of globin and gelatin are used.[7]

In traumatic shock a solution three times as hypertonic as Ringer's solution, with a hypnotic added, has given good results.[1]

The relief of pain is desirable, as restlessness tends to increase the degree of shock. Excessive doses of morphine tend to deepen the shock. Usually morphine, gr. 1/6, intravenously, with another gr. 1/6 subcutaneously, is sufficient.[3]

Blood volume can be increased by transfusion with whole blood. The British, out of their experience, calculated four pints of blood or plasma were necessary for the average severely shocked patient.[3]

The position of the shocked patient in bed depends upon the cause of shock and the extent of the injuries. Some patients do better in the head-up position, while with others the feet-up position is preferable.[4]

REFERENCES

1. Askatyan, Dr. E. A. *Amer. Review of Soviet Med.* Oct. 1944.
2. Crossman, Lyman, Week & Allen, Dr. Frederick M. *J. of Amer. Med. Ass'n.* Jan. 1946.
3. DeGowan, Dr. E. L. *J. of Iowa State.* Jan. 1944.
4. Duncan, Dr. G. W.; Sennoff, Dr. S. J.; Martin, Dr. R. C.
5. Gunther, Dr. Lewis. *U.S. Naval Med. Bulletin.*
6. Stead, Dr. E. A.; Warren, Dr. J. V. *Archives of Surg.* Jan. 1945.
7. Stead, Dr. E. A.; Brannon, Dr. E. S.; Merrill, Dr. A. J.; Warren, Dr. J. V. *Archives of Internal Med.* May 1946.

Oh Lord, keep us from hot heads that would lead us to act foolishly—and keep us from cold feet that would keep us from acting at all. — *Selected*

Aux Infirmières Canadiennes-Françaises

Pneumopathies chez les Enfants

ANTOINE LARUE, M.D.

LES INFECTIONS des voies respiratoires constituent chez les enfants en bas âge une des causes les plus fréquentes de morbidité. Contrairement à l'adulte, qui réagit assez classiquement à toute atteinte respiratoire, l'enfant jeune montre souvent peu de signes caractéristiques de maladie. La dyspnée est souvent légère, la toux peu marquée, les signes d'auscultation très peu nets, cela à cause du peu d'amplitude des mouvements respiratoires.

ETIOLOGIE

Les infections respiratoires, intéressant la trachée, les bronches, et les poumons, sont le plus souvent secondaires à des infections des voies aériennes supérieures, dont les muqueuses sont, dans l'hémisphère nord du continent, sujettes aux brusques variations climatériques y favorisant la congestion ou la sécheresse sur lesquelles les germes pathogènes communs se développent.

Le tissu lymphoïde des végétations adénoïdes et des amygdales dans son rôle de défense s'hypertrophie et fréquemment sert à son tour d'habitat à l'agent infectieux. La résistance du sujet, est-elle affaiblie par carence, malnutrition, mauvaises conditions hygiéniques ou encore par maladies débilitantes ou contagieuses? Les germes haut logés gagnent de proche en proche la trachée, les bronches, et enfin le poumon. Il est donc logique de classifier l'atteinte de l'appareil respiratoire en trachéite, bronchite, broncho-pneumonie, ou pneumonie selon la localisation de l'infection.

Dr LaRue est spécialiste des maladies des enfants et médecin à l'hôpital St-Sacrement, Québec.

BACTÉRIOLOGIE

Les micro-organismes les plus fréquemment rencontrés sont le pneumocoque, le streptocoque, le staphylocoque, et la bacille de Pfeiffer. Tous se rencontrent dans des prélèvements de gorge normale mais leur passage par contact d'un individu à un autre en augmente la virulence, et pour peu que dans leur voyage dans les différents cavums ils en rencontrent un qui est affaibli pour les raisons citées plus haut; ils s'y établissent et se reproduisent en grande quantité pour donner la maladie.

Ce phénomène d'augmentation de la virulence par repiquage est facile à constater lors des épidémies, les cas de début sont plutôt anodins alors que les derniers sont particulièrement morbides et parfois mortels.

SYMPTOMATOLOGIE

Chez l'enfant à passé sain, les symptômes des affections respiratoires sont sensiblement les mêmes que ceux que l'on rencontre chez l'adulte.

La bronchite, avec la fièvre légère qu'elle entraine, la conservation d'un bon état général, la toux grasse, et les gros râles humides sans autres signes fonctionnels, est facile à reconnaître.

La pneumonie, avec sa brusquerie, sa température élevée, ses signes physiques et radiologiques bien limités, est généralement assez typique.

La broncho-pneumonie donne un état général mauvais d'emblée, de la dyspnée avec battement des ailes du nez, du tirage, des foyers de râles humides, disséminés dans les deux plages pulmonaires. La température oscille, la toux est fréquente et fatigue le malade, les signes radiologiques révèlent une image caractéristique de l'affection.

Notons ici la symptomatologie un

peu spéciale des débiles et des cachectiques — chez ceux-ci, l'infection est à ce point grave et l'organisme à ce point affaibli que la température, la toux, la dyspnée, les signes auscultatoires sont parfois inexistants. Il faut souvent tabler sur un mauvais état général, une dyspnée douteuse ou une dyspépsie trainante, pour demander un examen radiologique révélateur.

Prophylaxie

Afin d'éviter la propagation des maladies respiratoires, les contacts avec les adultes souffrant de rhino-pharyngites devront être évitées.

Dans les hôpitaux, il est relativement facile pour tout le personnel médical, ayant accès aux nourrissons, de se prémunir du cache-bouche règlementaire. L'isolement précoce et maintenu des enfants atteints de maladies contagieuses, si fréquentes en complications d'ordre pulmonaire, mériterait qu'on y attache un peu plus d'importance.

Les fausses routes alimentaires ou l'inspiration de matières alimentaires vomies sont assez faciles à éviter lorsque les petits patients sont surveillés par une infirmière intéressée. De même les changements de position, chez les nourrissons, évitent la congestion des bases pulmonaires et la stagnation des mucosités à ces endroits. Enfin les traitements appropriés du rhino-pharynx malade, l'humidification normale, le chauffage tempéré des pièces, et une alimentation adéquate à l'âge sont autant de facteurs pouvant prévenir une complication pulmonaire.

Traitement

Parmi les anti-infectieux: Les sulfamidés, agissant à la fois sur les flores gram-positive et gram-négative et paralysant les virus, contribuent pour beaucoup à nettoyer les foyers d'infections et à les empêcher de gagner ailleurs; par contre, leur toxicité en font une arme qu'il faut manier avec précaution. La pénicilline en injections ou par voie buccale, grâce à son action remarquable et son innocuité, est un agent de premier ordre contre la flore la plus fréquente — la flore gram-positive. La stréptomycine, plus récente encore que les autres, comble le déficit de la pénicilline en agissant contre la flore gram-négative.

L'oxygénation: Contre la dyspnée, la cyanose, et l'acidose respiratoire l'oxygène reste le meilleur remède. Ce procédé de plus en plus répandu supplante l'ancienne saignée, sauf peut-être dans les cas suraigus avec fléchissement cardiaque par surcharge de la petite circulation.

L'humidification des chambres des pulmonaires prend un nouvel essor — on prétend que par ce procédé les sécrétions bronchiques sont diminuées et plus facilement éliminées et que l'air humide inspiré est moins irritant pour les muqueuses. On a mis au rancart les produits odoriférants trop irritants pour n'employer que la simple vapeur d'eau.

Les aérosols à la pénicilline demeurent un traitement de luxe, leur usage se limite surtout aux infections respiratoires supérieures, et est difficile en pathologie infantile.

La baisse dans le coût de ce produit permettra qu'on vulgarise son emploi en vaporisation dans les chambres de malades.

Les produits à base de créosote, ou autres désinfectants bronchiques, sont très à la mode dans les bronchites.

Enfin les stimulants respiratoires et cardiaques, de même que la transfusion sanguine, sont parfois appelés à soutenir le malade pendant que la médication anti-infectieuse fait son oeuvre.

Pronostic

Bien que meilleur depuis les nouveaux anti-biotiques, les procédés modernes d'hygiène, et les régimes alimentaires mieux adaptés, l'avenir de certains cas d'infections respiratoires demeure sérieux. Il s'agit le plus souvent alors de bactéries excessivement virulentes ou inattaquables par les médications récentes.

Whatever of dignity, whatever of strength we have within us, will dignify and make strong the labor of our hands; whatever littleness degrades our spirit will lessen them and drag them down.

— Sir Frederick Leighton

Notes from National Office

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association will be held in Suite 401, 1411 Crescent St., Montreal, on January 27, 28 and 29, 1949.

Job Analysis

Several months ago we wrote a little story about the Job Analysis Manual prepared by the Institutional Nursing Committee of the Canadian Nurses' Association. National Office continues to receive many requests for copies of this excellent guide. The other day we read an interesting article in the October, 1948, issue of *The Modern Hospital* entitled "Job Study Points the Way to Better Nursing." The article is really the report of a panel discussion given at a hospital conference. The director of nurses was an important member of the planning committee which started the hospital survey and included a job analysis and personnel study. The results of this interesting survey from a nursing point of view was the revamping of the nurses' working day. The starting time was moved from 7:00 a.m. to 8:00 a.m. The primary reason for the change of time was to adjust the abnormal hospital day as closely as possible to conform with the normal day of an average person. Most patients don't like to be wakened at the crack of dawn and tucked into bed when the lights go on.

A secondary factor, but one of considerable importance, was to make hospital employees' working hours more nearly conform with the schedule followed by workers in most other fields of employment.

The director of nurses in outlining the way in which this was accomplished stated that it was a co-operative venture, working with all departments within the hospital. Meetings of department heads were held to get their immediate reaction. Several weekly meetings were held and ground plans laid. Letters were sent to all doctors explaining the plan. Summing up the advantages of this change-over, the director of nurses has this to say: "I feel this is one of the most important changes we have made in nursing service and has definitely brought about the 'new look' in nursing." Won't you read the entire article and find out more about this interesting survey?

Student Recognition in Britain

Report comes from the Royal College of Nursing, Great Britain, that on and after January 1, 1949, as a result of the Whitley Functional Council's decision, the student nurse is to be recognized, financially, as a student. The nursing student will no longer appear on the salary schedule but will receive a training allowance which will place her in the same category as the student teacher. Out of the allowance, the student nurse will be required to pay for her living accommodation, etc. This is a big step forward as the principle of studentship has been recognized by the representatives of employing authorities. The *Nursing Times* of October 2, 1948, commenting on the changing attitude toward the student nurse, has this to say:

> . . . Living-in has had to be continued and emoluments given in place of an over-all salary. This is the chief cause of the separation of nurses in hospital from the rest of the community. If the student is given an allowance out of which she pays for her board and lodging, etc., will living-in remain the rule? . . . The accepted view that living-in is absolutely essential while in training is already being disproved, whether because of shortage of accommodation or for other reasons . . . The student nurses have called for student status. They must now, therefore, take far greater responsibility for themselves and their health. Without rules, a higher degree of individual discipline and responsibility is demanded.

I.C.N. Representative to U.N.

The report of Miss Effie Taylor on the activities of the representative from the International Council of Nurses to the United Nations makes interesting reading. In it she records the struggle of the I.C.N. for recognition, beginning with the first meeting of the United Nations held in San Francisco in July, 1945. Early in 1946, the I.C.N. sent a message to Dr. Thomas Parran, director of the United States Public Health Service, placing the resources of the I.C.N. at the disposal of whatever World Health Organization might be set up and requesting that the executive secretary of the I.C.N. might attend the first technical meeting to be held in Paris in March, 1946. Dr. Parran gratefully acknowledged this offer but said that the time was not ripe for such representation. After repeated written and personal contacts with the United Nations, the I.C.N. was notified that "the Council was not looked upon as having credentials entirely suitable for consultative status in the Economic and Social Council." The reason given for not endorsing the application was that, in the opinion of the department, nursing belonged in the World Health Organization.

Following a later interview with the International Council of Nurses' representatives and Dr. Chisholm, the Council was formally notified that the question of acceptance with the World Health Organization had been placed on the agenda of the meeting of the Interim Commission to be held in Geneva. To quote Miss Taylor:

> While we did not attain our goal, we were given the status of observer and may confer at any time with the Secretariat or Committees. It is promised that we will receive literature to keep us in touch with information of value to us.

World Health Organization

The World Health Organization held its first assembly in Geneva June 24-July 24, 1948. Miss Y. Hentsch represented the International Council of Nurses in the capacity of observer. Delegates and observers were present from seventy countries. One country only had included a nurse in its membership. Miss Lucile Petry, chief nurse, United States Public Health Service, acted as technical adviser to U.S.A. delegation. Five main committees were established: Program, Administration and Finance, Relations, Headquarters and Regional Organization, and Legal. On a recommendation of the program committee, the Assembly granted a priority to four programs for 1949. These are for the combatting of malaria, tuberculosis and venereal disease on a global scale, and maternal and child health. Among other programs approved for action were: Nutrition, public health administration, mental health, and the setting up of a Bureau of Medical Supply—penicillin, insulin, etc. With reference to nursing, it was recommended that the setting up of a committee on nursing be considered by the second World Health Assembly. In the meantime, nursing representation should be considered where appropriate in the appointment of expert committees. It has been pointed out firstly that, as the nursing profession has always been and will continue to be actively concerned in all health programs, it might be in the interest of WHO, and its future plans for world health improvement, to afford nurses the opportunity to participate in the activities of this organization; secondly, lest we forget, nurses through their international professional organ, founded in 1899, have been organized internationally for a longer time than any other group of professional women.

The Assembly approved that the staff for the study of the group of subjects, included under public health administration, should include at least one expert in public health administration and one well-qualified public health nurse in a position of responsibility. Dr. Brock Chisholm was elected and appointed as director general of WHO on the nomination of the Executive Board.

The newsletter published by WHO,

Geneva, September, 1948, carries an item on a new discovery to increase insulin supply. The new method, developed by Dr. Lindner of the Farbwerke Hoechst, Frankfurt-on-Main, makes it possible to preserve insulin-yielding pancreas glands without refrigeration. In the Lindner method, refrigeration is replaced by a chemical process of dehydration thus making it possible to store or transport the glands for several days at room temperature without damage. The obviation of the need for refrigeration plants permits the recovery from small slaughter-houses of most of the glands which otherwise would be wasted. As a result, the quantity of glands available for the production of insulin has been multiplied. Dr. Brock Chisholm has recommended to governments that the new method be put into operation wherever possible and that countries, where insulin is not extracted, put their own supplies of unused pancreas glands at the disposal of insulin-producing countries. The demand for insulin is expected to increase over the next few years. Thirty-five of the forty-six countries replying to the questionnaire sent out by WHO stated that they were not self-sufficient in regard to insulin supplies.

Tentative Congress Program

Approval has been given by the program committee of the I.C.N. for the release of the tentative program. Readers will no doubt be interested to learn that a nurse from Canada and one from the United States have been invited to contribute to the program on Monday, June 13, at the session on nursing education, while nurses from Great Britain, New Zealand, and China will participate in the session entitled "Meeting the Demands for Nursing Service." Visits of small groups to institutions and places of interest are planned as follows: Schools of nursing, hospitals, child welfare centres, a tuberculosis centre, schools, the town mission (voluntary relief work), factories, "own homes" and other modern dwellings, the old city of Stockholm. Any other requests for visits not listed should be made directly to the International Council of Nurses headquarters.

The arrangements committee is confronted with great difficulties in regard to hotel accommodation. There is a very limited number of hotel rooms available in Stockholm. Arrangements have been made to prepare lodgings during the actual days of the congress in Stockholm at nursing schools, hospitals, public schools, and military locations.

TENTATIVE PROGRAM FOR THE CONGRESS: June 12-June 16, 1949, Stockholm, Sweden. All sessions will be held in The Tennis Hall, Stockholm.

Sunday, June 12:

Registration in The Tennis Hall.

8 p.m. — Florence Nightingale Oration in four churches—two Catholic and two Protestant. The Oration will be delivered by the Archbishop of Sweden and the Bishop of Stockholm. Light-procession of student nurses. Songs by the Nurses' Choir. Organ music.

Monday, June 13:

10 a.m.-1 p.m. — Opening ceremony—music. Address of welcome: Vice-chairman of the Swedish Nurses' Association. The president of the I.C.N. will invite H.R.H. the Crown Princess to declare the conference open. Addresses by: The Prime Minister; the Director General of the Medical and Health Board; the Governor-General; the chairman, Union of Professional Women. Vote of thanks—two member countries of the I.C.N.

3 p.m.-6 p.m. — Nursing education — discussion.

Tuesday, June 14:

9 a.m.-11 a.m. — Shortage of nurses — discussion.

11 a.m.-1 p.m. — Relief work — discussion.

3 p.m. — Visits of small groups to institutions and places of interest as noted above.

Wednesday, June 15:

9 a.m.-12 noon — Medical care in Sweden—discussion.

2 p.m. — Reports: (1) Executive Secretary, I.C.N.; (2) chairmen, I.C.N. committees.

7 p.m. — Chronicle play—History of nursing in the northern countries.

Thursday, June 16:

Visits to country towns of Sweden.

Notes du Secrétariat de l'A.I.C.

Le Comité de Régie

Le Comité de Régie de l'A.I.C. tiendra une assemblée à Montréal à 1411 rue Crescent, les 27, 28 et 29 janvier 1949.

Analyse du Travail

Il y a quelques mois nous parlions d'un Manuel de l'Analyse du Travail, préparé par un comité de l'A.I.C. Cet excellent guide est en grande demande et les commandes arrivent nombreuses à nos bureaux.

Un article très intéressant sur le même sujet était publié en octobre 1948 par *The Modern Hospital*, ayant pour titre "L'Analyse du Travail Semble Nous Orienter Vers un Meilleur Nursing." Cet article à dire vrai est le rapport d'une discussion débattue lors d'une réunion d'une conférence d'hôpitaux.

Le rôle de la directrice des infirmières fut des plus important sur le comité chargé de préparer un plan d'enquête sur l'hôpital—enquête comprenant l'analyse du travail, des qualifications du personnel. Le résultat de cette enquête pour ce qui concerne les infirmières fut la modernisation des heures de travail: la journée commence à 8:00 au lieu de 7:00 a.m. La première raison, qui a amené ce changement, est de ne pas changer les habitudes du patient. La plupart des malades n'aiment pas à se faire éveiller au lever du jour et pas davantage à se coucher dès que les lumières s'allument.

Une autre raison de ce changement, considérée aussi très importante, est que les heures de travail du personnel des hôpitaux peuvent maintenant se comparer avantageusement à celles des employés divers.

La directrice des infirmières dit que ce résultat a été obtenu par la co-opération de tous les chefs de service. Dans une première réunion, l'on fit part du projet et l'on étudia la réaction de chacun, puis dans des réunions successives tenues à chaque semaine l'on élabora des plans. Une lettre fut adressée à tous les médecins expliquant le projet que l'on voulait mettre à exécution. En résumant les avantages de ce changement, la directrice des infirmières dit: "Je considère que ce changement est l'un des plus important dans le service hospitalier et les conditions de travail prennent un air vraiment '1949' pour notre personnel."

Ne manquez pas de lire cet article. Vous y trouverez beaucoup d'autres renseignements intéressants concernant cette enquête.

Le Statut d'Etudiante aux Elèves des Ecoles d'Infirmières de Grande-Bretagne

Le Collège Royal des Infirmières de Grande-Bretagne rapporte qu'à partir du 1er janvier 1949 les élèves des écoles d'infirmières seront reconnues comme des étudiantes. Ces élèves n'apparaîtront plus sur la liste des salariées, mais elles recevront, comme les élèves d'écoles normales, une allocation d'étudiante. Avec cette allocation, l'élève devra payer son logement, etc. Cette décision semble être la reconnaissance par les autorités du statut d'étudiantes pour les élèves des écoles d'infirmières.

La revue *Nursing Times* (2 octobre 1948), commentant la décision prise de donner des allocations aux élèves des écoles, dit:

"Au lieu de donner un salaire ou une allocation aux étudiantes, l'on a donné dans le passé l'entretien et une légère indemnité mensuelle. Ce traitement en faisait un groupe à part. Maintenant si l'élève reçoit une allocation d'étudiante, lui permettant de payer elle-même pour son logement, sa nourriture, va-t-elle continuer à loger à l'hôpital?

"L'idée, depuis si longtemps acceptée qu'il est obligatoire pour l'élève infirmière de loger à l'hôpital durant son cours, n'est plus acceptée. Est-ce à cause de la pénurie de logement ou pour d'autres raisons?

"Les étudiantes des écoles d'infirmières ont demandé un statut les mettant sur le même pied que les autres étudiantes. Il faudra donc qu'elles acceptent de prendre de plus grandes responsabilités, tel que le soin de leur santé, etc. L'absence de règlements oblige l'individu à une discipline personnelle beaucoup plus grande et à une plus grande compréhension de ses responsabilités."

La Représentante du Conseil International des Infirmières aux Nations-Unies

Le rapport de Mlle Effie Taylor est des plus intéressants. On y donne le compte-rendu de la lutte du C.I.I. pour être reconnu à la première assemblée des Nations-Unies, tenue à San Francisco en juillet 1945. Au début de l'année 1946, le C.I.I. envoya un message au

Dr Thomas Parran, directeur des Services de Santé des Etats-Unis, offrant de mettre à la disposition de l'Organisation Internationale de Santé les ressources que peut offrir le C.I.I., et demandant que la secrétaire du C.I.I. assiste à la première réunion du conseil technique tenue à Paris en mars 1946. Il y eut plusieurs échanges de lettres et le résultat final fut que la représentante du C.I.I. fut invitée à assister aux séances à titre d'observateur avec pouvoir en tout temps de conférer avec le secrétariat ou les comités.

L'ORGANISATION INTERNATIONALE DE SANTÉ

L'Organisation Internationale de Santé eut sa première assemblée à Genève en juin et juillet 1948. Mlle Y. Hentsch représenta le C.I.I. Soixante-dix pays avaient envoyé des observateurs ou des délégués. Un de ces pays comptait une infirmière parmi ses membres. Mlle L. Petry, infirmière en chef des Services de Santé des Etats-Unis, était attachée à la délégation américaine comme aviseur technique. Cinq comités principaux furent formés: programme, administration et finance, relation, organisation centrale et régionale, et législation. Sur la recommandation du Comité du Programme, l'assemblée décida que pour 1949 les quatre programmes devant avoir la priorité sur tous les autres seraient: la lutte contre la malaria, contre les maladies vénériennes et la tuberculose, la santé de la mère et de l'enfant.

D'autres programmes furent approuvés—la nutrition, l'administration dans l'hygiène publique, hygiène mentale, et l'organisation d'un bureau de fourniture médicale, tel que la péniciline, l'insuline, etc.

Pour ce qui concerne les infirmières, il fut décidé que l'organisation d'un comité sur le nursing serait considéré lors de la deuxième assemblée de l'O.I.S. Des infirmières seront nommées sur ce comité. L'on fit aussi remarquer que, comme les infirmières se sont toujours intéressées, aussi bien dans le passé qu'actuellement aux questions de santé, il serait avantageux pour l'O.I.S. de les faire participer aux activités de cette organisation.

Il ne faut pas oublier que les infirmières ont été les premières femmes à avoir une organisation internationale—dès 1899 elles étaient groupées.

Dans une lettre de nouvelles, publiée par l'O.I.S., datée de septembre 1948, l'on annonce une découverte susceptible d'augmenter la production de l'insuline. Il s'agit d'une méthode permettant de conserver les glandes pancréatiques sans les congeler. Le Dr Lindner de Frankfurt-on-Main a remplacé la méthode de congélation par un procédé de déshydratation, ce qui permet de conserver les glandes ou de les transporter à une température ordinaire sans inconvénient. Cette découverte permettra aux petits laboratoires, dépourvus de réfrigération, de conserver ces glandes précieuses, lesquelles autrement seraient perdues. La quantité de glandes permettant de faire de l'insuline a été grandement augmentée. Le Dr Brock Chisholm a recommandé aux gouvernements d'employer cette méthode et aussi de demander aux pays, là où l'on ne fabrique pas l'insuline, de mettre à la disposition des pays préparant l'insuline les pancréas qu'ils pourront conserver par cette méthode.

Une campagne universelle de lutte contre la tuberculose fut inaugurée par l'O.I.S. et par le Comité des Nations Unies de l'Aide aux Enfants. Le but du programme est la protection des enfants contre la tuberculose par le vaccin B.C.G.

Soixante-dix pour cent des enfants de moins de quatorze ans en Europe sont infectés par la tuberculose. La tuberculose dans les pays dévastés a un caractère épidémique. Plus de deux cents médecins et infirmières travaillent en Europe aux tests et à la vaccination anti-tuberculeuse. Des laboratoires, dirigés par l'O.I.S., produit et certifie le vaccin si nécessaire.

CONGRÈS INTERNATIONAL DES INFIRMIÈRES À STOCKHOLM

Une infirmière du Canada et une des Etats-Unis ont été invitées à adresser la parole le 13 juin; le sujet à l'étude ce jour-là est: Comment la profession d'infirmière peut-elle répondre aux demandes du public?

Des visites se feront par petits groupes aux institutions et aux endroits susceptibles d'intéresser les infirmières—les écoles d'infirmières, les hôpitaux, cliniques d'enfants, un centre anti-tuberculeux, diverses organisations sociales, et à la vieille ville de Stockholm.

La question du logement est difficile—la place dans les hôtels est limitée. Durant le congrès, les infirmières seront logées dans les écoles d'infirmières, dans les hôpitaux, dans les écoles, et dans les baraques militaires.

Projet du programme du congrès:

Du 12 au 16 juin à Stockholm, Suède, toutes les séances auront lieu au Tennis Hall.

Dimanche 12 juin: Inscription au Tennis Hall. 8:00 p.m.: Allocution en mémoire de Florence Nightingale sera donnée dans quatre

églises—deux catholiques et deux protestantes. L'Archevêque de Suède et l'Evêque de Stockholm ont accepté d'adresser la parole en la circonstance. Il y aura procession aux flambeaux par les élèves des écoles d'infirmières, des chants, et de la musique d'orgue.

Lundi 13 juin: 10 a.m.-1 p.m.: Ouverture du congrès. Musique. Adresse de bienvenue par la vice-présidente de l'Association des Infirmières de Suède. La présidente demandera à Son Excellence la Princesse Royale de déclarer le congrès ouvert. Discussion par le Premier Ministre, par le directeur des Services Médicaux et de Santé, le Gouverneur Général, la présidente de l'Union des Femmes Professionnelles. Vote de remerciements par les représentantes de deux pays faisant partie du C.I.I. 3 p.m.-6 p.m.: L'éducation de l'infirmière. Discussion.

Mardi 14 juin: 9 a.m.-11 a.m.: Pénurie d'infirmières. Discussion. 11 a.m.-1 p.m.: Travail d'urgence. Discussion. 3 p.m.: Visites aux institutions et aux endroits d'un intérêt particulier tel que déjà noté.

Mercredi 15 juin: 9 a.m.-12 p.m.: Les soins aux malades en Suède. Discussion. 2 p.m.: Rapports: (a) De la secrétaire du C.I.I. (b) Des convocatrices des comités. 7 p.m.: Pièce historique sur le nursing dans les pays du nord.

Jeudi 16 juin: Visites aux villes de province en Suède.

The Metropolitan School of Nursing

Administration

A copy of the auditor's statement for the Canadian Nurses' Association, and one for the Canadian Red Cross Society, were forwarded to the general secretary-treasurer on June 17, 1948. This statement shows that we have been able to absorb the organization expenses from January 1, 1947, in the first half-yearly transfer of $20,000. At present we are trying to reserve a proportion of the second transfer to apply toward the greatly increased equipment which will be required for the new building.

Accommodation

At the meeting of the Executive Committee of the C.N.A. on June 30, it was reported that financial arrangements for the new school building had been completed. Since then building has commenced. The date of completion is uncertain. Our present capacity is now taxed to the utmost and it is clear that no further students can be accepted till the new building is available, whenever that may be.

It will be recalled that at the meeting of the Demonstration School Committee in Windsor in May, 1948, it was decided that the next class of students should be admitted in the fall of 1948, and that temporary accommodation should be sought for this group. Attempts to find another house were unsuccessful, and finally arrangements were made to have the students sleep in rooms in private houses in the vicinity of the school and have meals and classes at the school.

Students

Class of February, 1950: One student of this group was found unsuitable for nursing and resigned on September 29. The group wrote Part I of the Registration Examinations of Ontario in October, 1948.

Class of October, 1950: Twenty-four students were admitted and, as stated above, are rooming outside the school. The reason for having this new group outside and keeping the old group in the house is that the latter, who are now practising at the hospital, had already considerable travelling to do daily. The distribution of the new group by provinces is: British Columbia—4, Manitoba—1, Ontario—17 (Windsor—5), Prince Edward Island—1, Saskatchewan—1.

As far as academic qualifications are concerned, this new group is superior to the first. In the first group, educational qualifications are as follows: Secondary school graduation or university entrance, 10; more than university entrance, 1; senior matriculation, 1.

Second group: Secondary school graduation or university entrance, 12; more than university entrance, 3; senior matriculation, 7; B.A., 2.

For the class for the autumn of 1949 there have already been: enquiries, 113, with applications, 10; of these 3 have been definitely refused.

Hospitalization Insurance

This was discussed at the May meeting of the Educational Policy Committee, and it

was decided to present the advantages of such a plan to the students. This was done and 11 of the first group of 12 students and all the second group of 24 are now insured. All the graduate staff and the domestic staff are also insured.

ELIGIBILITY OF GRADUATES

The directors of eight Canadian university schools of nursing were written regarding the eligibility of future graduates from this school to enter university for post-graduate courses. Replies as follows have been received:

McGill University, Queen's University, University of Alberta, and the University of Toronto state that they consider our students eligible for post-graduate work. The directors of the schools of nursing of the University of Montreal, of Ottawa, of Western Ontario, and of British Columbia are not ready yet to give a decision. No reply has been received from the University of Manitoba.

NETTIE D. FIDLER, *Director*

Nursing Sisters' Association

Where sixty-five women are gathered together there is bound to be a fair amount of chatter but when the sixty-five women are nursing sisters we can only say: "The tumult and the shouting died" as the national president of the Nursing Sisters' Association, Mary Edgecombe, called the meeting to order at 3:30 p.m. on Tuesday, June 29, 1948, at Mt. Allison University, Sackville, N.B. The sixty-five nursing sisters present represented thirteen of the eighteen units now organized in the association, which boasts a membership of 1,159 as against 807 in 1946.

The meeting was pleased to hear from Miss Maude Wilkinson that the directory of the Nursing Sisters' Association of Canada was ready for distribution and decided upon a thirty-five cent per copy charge for these books, the directories to be ordered by each unit for its individual members.

Miss Edna Moore, convener of the Incorporation Committee, reported that incorporation of the association was progressing favorably, though there had been one or two unchartered obstacles which had caused some delay in the normal progress of such a procedure. The final settlement of this matter will, it is hoped, clear the way for future executives to act with a legal constitution and will do away with many present troublesome problems. Miss Moore and her committee are to be complimented upon their patience, tact, and pertinacity.

The meeting then voted in favor of disposing of the Rehabilitation Fund which Miss Sarah Miles, the convener, reported had still a balance of $2,872.87, after donating over a thousand dollars earlier in the biennium to the British Nurses' Relief Fund and C.N.A. War Memorial Fund. This disposal was made as follows:

One thousand dollars to Miss Hentsch, of the International Red Cross, for the sick nurses of Europe; $1,000 to British Empire Nurses War Memorial Fund; balance to C.N.A. War Memorial Fund.

On the evening of June 29, the Saint John Unit, of which Miss I. Wetmore was president, was hostess to the nursing sisters attending the meeting. A most successful dinner was held at which one hundred were present. Dr. W. T. R. Flemington, president of Mt. Allison University, was a very happy choice as guest speaker. Knowing so well the background of many of his audience he rolled back the years and made memory live again.

The nursing sisters who were able to attend the business meeting and the dinner were indeed fortunate. Many old friendships were revived, many new ones formed. The

(*Concluded on page 62*)

Climo, Saint John

MARY EDGECOMBE

Nursing Profiles

Marion Christine Livingston has assumed her work as chief superintendent of the Victorian Order of Nurses for Canada thus becoming the eighth nurse to fill this important office since the Victorian Order was first established in 1897.

Born in Durham, Ont., Miss Livingston's earliest ambition was to become a nurse. "It probably sounds trite," she says, "but I never considered any other career and I've never had a moment's doubt about my choice." This singleness of purpose led her through her training at the Hamilton General Hospital and all of the positions she has held since her graduation in 1930. The recipient of a scholarship from her school of nursing, Miss Livingston entered the School of Nursing of the University of Toronto immediately and qualified in public health nursing. She has since studied for her B.Sc. from Teachers College, Columbia University.

Two years in the out-patient department of H.G.H. persuaded Miss Livingston that her interest lay in reaching people in their own homes. She joined the staff of the Hamilton Department of Public Health in 1934 and for four years participated in the generalized public health nursing program. Then, in 1938, she took the first step up the long road that has brought her to her present pre-eminent position. She went to Montreal and joined the V.O.N. as a district nurse. Her capabilities and qualities of leadership were quickly recognized. After some eighteen months doing ground-floor work she was appointed nurse-in-charge of the Moncton branch. Six months later she was called to the V.O.N. national office as a supervisor. In 1943, she was named second assistant superintendent, moving on to become district superintendent of the large Montreal branch in 1946.

Miss Livingston has always been an active participant in nursing association activities. She was chairman of the Public Health Section, R.N.A.O. During the past biennium she was convener of the Publicity Committee, C.N.A., a responsibility for which her understanding of the value of good public relations had prepared her. Miss Livingston is a member of the Soroptimist Club and of the Business and Professional Women's Club.

Notman, Montreal

CHRISTINE LIVINGSTON

Velma Elisabeth Brown has been appointed director of Outpost Hospitals with the Saskatchewan Division of the Canadian Red Cross Society, succeeding **Mary G. Donoghue.** A native of Saskatchewan, Miss Brown graduated from the Saskatoon City Hospital in 1938. She became head nurse on the neurosurgical ward of S.C.H. in 1942. The following year she enlisted as a nursing sister with the R.C.A.F. and saw service in the Maritimes and Newfoundland as well as

VELMA E. BROWN

in her own province. On her discharge from active service, Miss Brown enrolled in the University of Western Ontario whence she received her B.Sc.N. in 1948. She is an enthusiastic sportswoman, enjoying tennis and swimming in particular.

Sister Helen Marie Darrah has returned to her native city of Saint John as the director of nurses at St. Joseph's Hospital. A graduate in 1944 of Holy Family Hospital, Prince Albert, Sask., she obtained her B.Sc.N. from St. Louis (Mo.) University in 1948. In the interim she had been floor supervisor at Holy Family Hospital.

Catherine Perkins has taken up her duties as supervisor of public health nursing with the Victoria Department of Health. Born in England, Miss Perkins received her training at the Maple Creek (Sask.) General Hospital, graduating in 1928. For nine years she was assistant matron at her home hospital, then decided to enter public health nursing. She received her certificate from the University of British Columbia in 1940 and became public health nurse with the Children's Aid Society in Vancouver.

In December, 1941, Miss Perkins enlisted with the R.C.A.M.C. and saw service in England, France, Belgium, and Holland with No. 8 Canadian General Hospital. Upon her discharge in 1945, she enrolled for the course in public health supervision at the McGill School for Graduate Nurses and upon its completion was appointed assistant supervisor of Unit I of the Metropolitan Health Committee, Vancouver.

Faith Flora Hodgson has been named the superintendent of nurses of the sanatorium at Tranquille, B.C. After graduating in Arts from the University of British Columbia, Miss Hodgson entered the school of nursing of the Royal Jubilee Hospital, Victoria, whence she graduated in 1941. Following brief experience as staff nurse at the Queen Alexandra Solarium for Crippled Children, Mill Bay, B.C., Miss Hodgson enlisted as a nursing sister with the R.C.N. In addition to her service in Canada, she was with *H.M.C.S. Niobe* in Scotland. When she was demobilized, she enrolled in the course in hospital administration at the McGill School for Graduate Nurses. For the past two years she has held the position of assistant superintendent of nurses at the Trail-Tadanac (B.C.) Hospital. Oil painting and sketching provide Miss Hodgson with relaxation, with swimming, canoeing, and hiking as her favorite outdoor sports.

SISTER HELEN MARIE

Rhoda Ferguson MacDonald has accepted the superintendency of the Payzant Memorial Hospital, Windsor, N.S., succeeding **Irene Mellish** who has taken the position of superintendent of the Eastern Kings Memorial Hospital, Wolfville, N.S. Miss MacDonald graduated from the Glace Bay General Hospital in 1928, and received her certificate as instructor in schools of nursing from the University of Toronto ten years later. She has held many and varied positions of responsibility in the years that have followed, the most recent being superintendent of nurses at Aberdeen Hospital, New Glasgow.

Knight, Victoria

CATHERINE PERKINS

Saskatoon Star-Phoenix

MURIEL JARVIS

Muriel Amy Jarvis is now the superintendent of nurses at the Saskatoon Sanatorium. Graduating in 1943 from the Saskatoon City Hospital, Miss Jarvis returned to the staff there, first as night supervisor, then nursing arts instructor, with a few months as assistant director of nursing for good measure. She was particularly interested in administration so entered the McGill School for Graduate Nurses and secured her certificate in this branch of nursing. Latterly she has been at the Qu'Appelle Valley sanatorium as instructor in the affiliated course in tuberculosis for student nurses. While at Fort San she was a member of the Soroptimist Club.

Pearl Morrison, superintendent of Queen Elizabeth Hospital, Toronto, was recently elected president of the Ontario Hospital Association. Miss Morrison has the experience of many years of active association with

Ballard of Eaton's

PEARL MORRISON

hospitals to acquaint her with the numerous perplexing problems the association has to meet. Graduated from the Welland (Ont.) General Hospital in 1913, she served overseas with both the Q.A.I.M.N.S. and the C.A.M.C. during World War I. Afterwards, she was assistant superintendent in Indianapolis and Sarnia, and superintendent of nurses in Fort William, Washington, D.C., and Owen Sound. Our congratulations to Miss Morrison!

To **Elizabeth L. Smellie, C.B.E., R.R.C., LL.D.,** former chief superintendent of the Victorian Order of Nurses for Canada, goes the distinction of being the first nurse to be appointed to the Dominion Health Council. This Council consists of the deputy ministers of health from each of the provinces together

Notman, Montreal

ELIZABETH SMELLIE

ANNE WRIGHT

with representatives from labor, agriculture, scientific research, and women's organizations. The only other woman on the Dominion Health Council is Mme Pierre Casgrain of Montreal.

Lacking a few months of twenty-two years in the arduous and exacting position of superintendent of the St. Catharines (Ont.) General Hospital, **Anne Wright** has retired. She graduated from the Toronto General Hospital in 1919, then joined the staff there as operating-room supervisor. In 1921 she became second assistant superintendent of nurses at T.G.H., going as assistant superintendent of nurses at the Ontario Hospital, London, for one year prior to her posting at St. Catharines. It takes only a few lines to record these facts but the influence which she has exerted over the hundreds of nurses whose training she directed will last for many years to come. Her kindliness, her calm dignity, her fair-mindedness, and her devotion to her work have made their mark on hospital and community alike. She has rendered valiant service over a long period in a position of trust. Our felicitations follow her in her retirement to her old home in Mt. Forest, Ont.

In Memoriam

Julia C. Stimson, who was superintendent of the United States Army Nurse Corps from 1919 to 1937, and who became well known to Canadian nurses when, as president of the American Nurses' Association, she was one of the guest speakers at the C.N.A. convention in Montreal in 1942, died on September 30, 1948, at Poughkeepsie, N.Y., following surgery. Miss Stimson graduated from the New York Hospital in 1908 and began her career as superintendent of nurses at Harlem Hospital in New York. In 1911 she went to Washington University where she became director of hospital social service and also superintendent of nurses at the university hospital. She joined the Army Nurse Corps in 1917 and accompanied Base Hospital No. 21 overseas as chief nurse. The first woman given the rank of major in the American army, she was promoted to the rank of full colonel in 1945. For her service overseas, Colonel Stimson received the Distinguished Service Medal; was cited for "exceptionally meritorious and efficient service"; received the Royal Red Cross, First Class, from Great Britain, and the Médaille de la Reconnaissance Française and the silver Médaille d'Hygiène Publique from France. She was awarded the honorary degree of Doctor of Science by Mt. Holyoke in 1921.

Always active in nursing affairs in the United States, the news of her sudden death was received with a sense of shock.

* * *

Sister M. Austin (Catherine Mugan), who died recently at the House of Providence in Kingston, was one of the first graduates of the St. Vincent de Paul School of Nursing, Brockville, in 1906.

* * *

Lenore Bowie, who graduated from St. Michael's Hospital, Toronto, with the class

Blackstone Studios, New York

JULIA STIMSON

of 1927, died on September 7, 1948, in New York City.

* * *

Ileene Lavina Bruton, who had been on the nursing staff of the McKellar Hospital, Fort William, since her graduation there in 1946, died on October 31, 1948, following a cerebral hemorrhage, at the age of twenty-five.

* * *

Mrs. Jack Charles, who graduated from St. Paul's Hospital, Vancouver, and who served on the staff there for many years, died on September 20, 1948, at the age of forty-eight.

* * *

Ina Cook died in Sackville, N.B., following a brief illness. Until fifteen years ago Miss Cook was a supervisor at the Berkeley General Hospital, Oakland, Calif. She had been on the staff of the Sackville Hospital until the time of her illness.

* * *

Berthe (Perry) Davis, who served overseas in World War II as a nursing sister with No. 23 Canadian General Hospital, died in Halifax on October 15, 1948.

* * *

Frances Margaret Fraser, who was the first superintendent of the Children's Hospital, Halifax, died on October 21, 1948, at the age of seventy-seven. Miss Fraser was a graduate of the Hospital for Sick Children, Toronto, with post-graduate work at the Roosevelt Hospital, New York. She served overseas as a nursing sister during World War I.

* * *

Clare Goodwin, who graduated from St. Michael's Hospital, Toronto, in 1911, died suddenly as the result of an embolism on August 27, 1948. Following graduation Miss Goodwin worked for fourteen years in the United States, returning to Toronto to engage in private duty. She was on the staff of the Providence Hospital, Moose Jaw, at the time of her death.

* * *

Sister M. Felicita Grace, who graduated from St. Michael's Hospital, Toronto, in 1938, died on June 16, 1948.

* * *

Mrs. J. S. Matthews, who served as a nursing sister with the C.A.M.C. during World War I, died recently in Vancouver.

* * *

Andre (Deguire) Palmer, who graduated from St. Michael's Hospital, Toronto, in 1933, died suddenly on August 3, 1948.

Bertha Richards, who graduated from the Boston City Hospital, was later attached to the staffs of hospitals in New York City, and was matron of the Children's Shelter in Winnipeg, died recently at Brockville where she had resided for the past five years.

* * *

Elizabeth Ziolkoski, who had completed her second year in training at the Yorkton General Hospital, Sask., died on October 3, 1948, at the age of twenty-one.

Prevention of Premature Arteriosclerosis

Owing to a very large extent to the reduction of deaths from coma, diabetics now live much longer than before the discovery of insulin. They, therefore, now live long enough to develop arteriosclerosis. This premature development of arteriosclerosis in the diabetic is not inevitable. A high carbohydrate-low caloric diet, if properly employed, seems to be capable of postponing this condition to an appreciable extent. Satisfactory results are due to the effect of the diet on the plasma cholesterol. One of the most striking effects of this diet proved to be an immediate and sustained reduction of the plasma cholesterol level.

A second factor of significance in the prevention of premature arteriosclerosis is the control of the diabetes. Regardless of the severity of the disease and of the age of the patient, a direct relationship has been found between the degree of control and the appearance of premature sclerosis of the vessels.

Finally, one of the most striking effects of the high carbohydrate-low caloric diet is nitrogen retention. It appears reasonable that the postponement of arteriosclerosis noted with this diet may be in part due to the general improvement of nutrition which accompanies improved protein metabolism and thus increases resistance to degenerative changes.

— I. M. RABINOWITCH, M.D.

Perforations

Perforations of the digestive tract occur from different lesions in the following order of frequency: appendicitis, duodenal ulcers, gastric ulcers, colon carcinomas, colon diverticula and Meckel's diverticulum.

Student Nurses

Bronchiectasis and Lobectomy

MARGARET WOOD

I DID NOT realize that a person would be able to live a normal life after having a lobe of the lung removed. This patient's diagnosis was bronchiectasis. This is a condition in which the finer divisions of the bronchial tubes become dilated due to the presence of a foreign body, a sequela of empyema, or it may follow chronic infection of the lungs such as whooping cough, bronchitis, or influenza. The dilatation is a relatively late result of the chronic inflammatory process. Early bronchial dilatations are usually cylindrical. Later, they tend to be fusiform and finally sacculation may be expected. By the time bronchial dilatation has occurred the inflammatory process is usually productive and the bronchi of the affected region have become filled with pus or mucopus. This pus can eventually lead to chronic abscesses. As the process becomes older it is likely to become more extensive and, sooner or later, the pleural changes add to the pathology. The visceral and parietal layers of the pleura adhere, there is a connective tissue overgrowth, and in cases of long duration the heart and the mediastinal contents are pulled to the affected side because of the contraction of scar tissue. Seldom is an entire lobe involved. Usually it is that part of the lobe nearest the hilus which may have a more or less symmetrical tubular enlargement. The cases occurring in adults are rather obscure, the probable origin being doubtful. Diagnosis is made by the introduction of lipiodol; this substance is opaque and casts a shadow.

Miss Wood is a student nurse at the Vancouver General Hospital, B.C.

HISTORY

Elizabeth is a thirteen-year-old child of English ancestry. There are no family responsibilities or social problems which might affect her health. Although she has missed much of her schooling she is extremely intelligent for her age.

This child weighs 87 pounds. She has neither gained nor lost much weight for the past two years. For her height, which is five feet one inch, she should weigh from 100 to 110 pounds; therefore her caloric requirement would be approximately 2800 per day. She did not get much pleasure out of eating because her appetite was never very good, but she did get an adequate daily diet. She has been taking tonics for the past three years; these have helped considerably to make her feel stronger, healthier, and more energetic. She has regular elimination habits, ten to twelve hours sleep each night, and plenty of fresh air. Her doctor advised her not to take part in physical education at school because she was not strong enough. She has spent most of her recreational time drawing and reading.

For the past two or three years Elizabeth has had a continuous history of recurrent upper respiratory infections. Before then she had had measles, chicken pox, mumps, and whooping cough, the latter being followed by an attack of pneumonia and pleurisy. It was at this time the first sign of blood appeared in her sputum. She had a bronchiogram done which showed extensive bronchiectasis of the right lower lobe of the lung. The doctor gave her injections to keep her frequent colds at a minimum. Early in the disease her physical signs

were few. On the deepest inhalation a few coarse moist râles might have been heard, but without deep breathing the râles are easily overlooked. She appeared to be in good condition and her only complaint was an occasional moderate cough. Later the symptoms and signs tended to become more obvious. The coarse râles were easily heard unless the bronchi had been cleared by coughing. As time went on her cough became more severe, especially in the morning, often paroxysmal in character and recurring at intervals throughout the day. A change in position would often start a coughing paroxysm.

Physical Findings

A bronchoscopy was done on May 4. The right bronchus was found to contain a moderate quantity of mucopus which was sucked away. The left bronchus contained practically none. Shrinking material was applied to both the lower lobe bronchi. No evidence of obstruction was detected. The x-ray of May 7 showed that the markings in the right base were unusually dense but that there was no evidence of parenchymal infiltration. The lobectomy, in which the right lower lobe of the lung was removed, was performed on May 8. In the x-ray the following day there was no sign of free fluid or air present in the right chest and the mediastinum seemed to be in the normal position. On May 11, the x-ray showed that there was a moderate degree of effusion in the basal and lower axillary portion of the right hemithorax. The right upper lobe seemed to be fairly well expanded. There was a slight shift of the mediastinum to the right. The axillary portion of the resected sixth rib seemed to be unusually elevated in reference to its vertebral end. On May 20, in comparison with the previous examination, the right-sided pleural effusion showed evidence of slight diminution. The pneumothorax was no longer visible.

Laboratory Findings

The pre-operative urinalysis was normal. The blood count was also normal, but the percentage of hemoglobin was only seventy-three. The post-operative urinalysis was normal with a slight trace of acetone and yeast. The next urinalysis had a slight trace of albumin, uric acid, and epithelial cells.

Nursing Care

Cure is difficult since the damage to the bronchi is permanent. In general there are three types of treatments—postural drainage, general hygiene, and various operations. Postural drainage results in a considerable emptying out of the cavities of the loose bronchial secretion. The nursing care must provide for the conservation of the patient's strength and the building up of her body resistance. The main factors are rest, fresh air, and a high protein diet. If a foreign body is present the condition is improved or cured by the removal of the body. In other cases, a bronchoscopy with aspiration of the purulent material will result in improvement. But in Elizabeth's case, the disease was localized in the affected portion of the lung which, therefore, was surgically removed. Operative procedures of this character are limited more or less to those cases in which the involvement is wholly or chiefly unilateral.

Lobectomies of this type are performed under intratracheal anesthesia. A wide incision was made between the ribs to expose the pedicle of the lung. After the diseased tissue was removed the chest wall was tightly closed and a drainage tube inserted into the pleural cavity. This was an air-tight suction. The operation should not be performed during seasons when respiratory infections are frequent. The patient's pre-operative condition should be improved as much as possible. This was done by a bronchoscopic aspiration, regular postural drainage, and an adequate diet including high proteins, vitamins, and glucose drinks to within four hours of the operation. Several days preoperatively a pneumothorax was given to make the operation less shock-producing.

The drugs that were started four

days pre-operatively were multicebrin and penicillin, which were used to help keep the body resistance to infection high. Seconal gr. 1½ h.s., morphine gr. 1/12, and scopolamine gr. 1/200 were the pre-operative medications ordered. During her operation, Elizabeth received 2000 cc. of blood. The post-operative medications ordered were dilaudid gr. 1/48 p.r.n. for pain and morphine gr. 1/16 for restlessness. Codeine gr. ½ was substituted for the dilaudid on the fourth post-operative day because dilaudid is so habit-forming.

On recovery from shock, Elizabeth was kept in Fowler's position in an oxygen tent. In order to keep her in this position without strain, she was properly supported with several pillows, particularly under the knees. The patient should be encouraged to lie on the operative side as much as possible because this position will supply support to the weakened wall, increase lung compression, and aid in expectoration. Frequent turning, with assistance at first, is necessary.

The drainage tube which is attached to a suction bottle is immersed in water. This tube provides a constant negative pressure in the pleural cavity and must at no time become blocked. When the suction bottle is being emptied, air must not enter the drainage tube as this would force the lung to collapse. Dyspnea is present for the first week due to the sudden decrease in lung tissue, cardiac disturbance, and pain. Abdominal distention must be watched for, because this will restrict the downward excursions of the diaphragm and limit respirations. Special care should be taken to prevent restriction of the chest.

Deep breathing was encouraged and only small amounts of morphine were given in order to prevent excessive bronchial secretions. The temperature and pulse increased after the operation. This is probably due to the trauma of the operation and the escape of toxic products into the general circulation. Penicillin was given to bring the temperature back to normal. It is essential that the patient expectorate every half-hour day and night to avoid the retention of secretions with a resulting reinfection. Small amounts of secretions are carried by the cilia to the bifurcation of the trachea but from this point on they must be raised by coughing. Coughing after the operation was very difficult because of pain and the restriction of abdominal muscles; therefore it was the duty of the nurse to aid Elizabeth to cough as much as possible. For the first few days after the operation there was very little sputum due to her inability to cough.

During the following week, large amounts of accumulated secretions were expectorated. However, as the lung rested, the amount of sputum gradually diminished. The fluid intake was forced and high caloric feedings were given. Recreational therapy was most important in aiding her to recover. The complications to be watched for were atelectasis of the remaining lobes, sepsis, pericarditis, pulmonary edema, and cerebral abscesses.

The charting was most valuable to the doctor in order that he might see the gradual improvement in his patient. The pre-operative postural drainage produced approximately six ounces of greeny yellow, foul-smelling mucus each day. Elizabeth's temperature, pulse, and respirations were normal pre-operatively. The medications were charted before she left for the operating-room. She had been locally prepared for the lobectomy and a dry sterile dressing applied the evening before the operation. In the morning the sterile preparation was done with alcohol and three hours later it was redone with gasoline. The patient was in the operating-room five hours. When she returned to the recovery room she was semi-conscious, her color was good, her pulse 130, respirations 30, and blood pressure 140/76. Her respirations were rapid and slight dyspnea was noted. The drainage from the suction tube was a clear, red fluid. Her highest post-operative temperature was 101.2. By the third day, post-operatively, her total intake averaged 1500 cc. and her total output approximately 700 cc.

It was noted that she would only move with great persuasion because of so much pain. By the fifth day, post-operatively, she was moving about much more freely. Her appetite improved as she went from a fluid to a soft diet. She had oxygen for two days and had the drainage tube inserted for five days. By the tenth day post-operatively her sutures were removed and she sat up in a chair for the first time.

The Convalescent Period

Immediately post-operatively, Elizabeth was taught to take deep breaths and to move and cough frequently. Each day she was persuaded to exercise the arm on the operative side more and more. Her total convalescent period should be at least two months. Gradually she should take part in social and physical activities. If it were possible a warm dry climate would be beneficial as she should be protected as much as possible against all acute respiratory infection both during and after her convalescent period.

Conclusion

The most important observation about this patient was that the operation appeared to be a success. If all the diseased lung structure is removed it is extremely rare for any further bronchiectasis to develop. Even during her convalescent period her appetite and general condition were noticeably improved. After seeing Elizabeth both pre- and post-operatively I can now realize how beneficial this operation was. Think of the happiness that this delicate operation will bring to a child who will now be able to lead a normal life in her future years.

Book Reviews

Nursing in Diseases of the Eye, Ear, Nose and Throat, from the Manhattan Eye, Ear and Throat Hospital, New York City. 309 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 8th Ed. 1948. Illustrated. Price $3.30.

Reviewed by Z. Beattie, Ophthalmology Supervisor, Royal Jubilee Hospital, Victoria, B.C.

The eighth edition of this interesting textbook contains all the subject matter of the seventh, plus the newer methods of treatment as suggested by medical advances since that time. Many of the chapters are similar to those in the previous text, but the new photographs that have been added are valuable from a teaching standpoint. The nurse interested in surgery of this type will benefit by the illustrations of set-ups.

It is interesting to note that information regarding some of the new drugs has been added. The antihistamine group, such as benadryl and pyribenzamine, as well as antibiotic agents, such as penicillin and streptomycin, and also vitamin P and rutin expand the reader's knowledge.

It must not be forgotten that the student or graduate nurse interested in this field requires considerable detail to understand the importance of very careful management of the treatment and nursing of eye, ear, nose and throat patients. The question arises "Where can I read of nursing care of these particular cases?" In a book written for nurses caring for these patients, particularly eye cases, more detail should be given to techniques of nursing care.

Student and graduate should find this book valuable as a text and reference book, especially with the added discussion questions following some of the chapters, and with the glossary at the end of the book. I recommend it as a valuable addition to any nursing library.

Neuropsychiatry for Nurses, by Irving J. Sands, M.D. 397 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 5th Ed. 1948. Illustrated. Price $3.30.

Reviewed by L. O. Kitchen, Superintendent of Nurses, Falconwood Hospital, Charlottetown, P.E.I.

In all nursing fields, the nurse at some time comes in contact with abnormal behavior problems. It is, therefore, of the greatest importance that all nurses have a working knowledge of those factors effecting human behavior. This book places the necessary information before us in a clear, concise manner. Each phase of the subject is dealt with and is presented so that it may easily be assimilated and applied.

In order to understand human behavior it is first necessary to know the anatomy of the brain and spinal cord and those parts of the body influencing behavior. In the first chapters of his book, Dr. Sands gives us a clear word picture of the anatomy of these parts of the body.

Then, in the following chapters, he deals with endocrine glands, elementary psychology, and common neurological and psychological disorders met in the practice of nursing. These subjects are well presented and give the nurse knowledge of the prescribed treatment of the various conditions, as well as the signs and symptoms of the disorders.

This book could be used as a text for psychiatric instruction for nurses as well as supplementary reading for nurses engaged in any branch of the profession. It would be invaluable as a reference book in any hospital library.

Elementary Medical Physics, by Howard O. Stearns. 354 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Illustrated. Price $4.75.

Reviewed by Sister Melina Trottier, Science Instructor, St. Boniface Hospital, Man.

The author's main objective in writing this book is to provide the student nurse and premedical students with the practical applications of the various laws of physics as they are studying the principles. The author also aims at helping the same students to understand the principles which underlie the use of the various devices which the hospital makes use of in the treatment of its patients. While the book was intended primarily for premedical students or students who have had some previous understanding of the physical laws governing nature, the student nurse will find in it the practical application of many of these physical principles which she uses in her daily duties, and the understanding of which is conducive to more intelligent nursing care of her patients and makes the profession of nursing more interesting.

The book is written in a clear and easily read form with perhaps a superfluity of formulae for student nurses. The illustrations are numerous and practical. They are helpful in clarifying the principle stated.

The nurse will be particularly interested in Chapter X where heat measurement and metabolism are discussed with special reference to her life activities. The numerical headings given to the various topics treated in each chapter guide one's reading and facilitate the taking of notes.

If the book were intended to be used as a textbook for student nurses, one would suppose that physics would be a prerequisite to admission to the school. In some provinces, physics is not considered an essential subject.

As a reference book, the various schools of nursing would benefit by placing it in their school library.

The Rehabilitation of the Patient—Social Casework in Medicine, by Caroline H. Elledge. 112 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1948. Price $3.00.

Reviewed by P. A. MacCall, Social Service Department, Royal Victoria Hospital, Montreal.

This book was written with a view to studying the contribution of the medical-social worker in the rehabilitation of the handicapped patient. In the final analysis, however, the book achieves far more. Mrs. Elledge, in the course of her evaluation, has given a fascinating and illuminating account of the role of a medical-social worker. A book of this calibre should go far in interpreting and introducing medical-social work to the medical and nursing professions in particular.

The material is presented clearly and is well illustrated with case histories. These are brief but human accounts of a varied nature. In one instance, an adolescent boy was helped to accept amputation and an artificial limb but still continue to be a normal outgoing person; in another a young woman, who used her poliomyelitis disability as an excuse to withdraw from life, was helped to overcome her disability to the point where she became a self-respecting person supporting herself. Mrs. Elledge shows how the medical-social

worker makes use of the resources—first, within the individual and, secondly, in the community—to achieve her purpose. If all the case histories do not turn out to be "success stories" it is because medical-social workers are aware that there are many failures. They are also aware, however, that, with increasing knowledge on the part of physicians and nurses of the value of social casework in medical care, and with increasing knowledge of social casework itself on the part of medical-social workers, the failures will become fewer and the successes spread over a far greater field than is possible at the present time. Mrs. Elledge has made no small contribution toward this end with her book.

Teaching Psychotherapeutic Medicine. An Experimental Course for General Physicians. Edited by Helen Leland Witmer, Ph.D. 464 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1947. Price (in U.S.A.) $3.75.

Reviewed by Kathleen E. Cherry, Supervisor, Central Supply Room, Ross Memorial Pavilion, Royal Victoria Hospital, Montreal.

This book describes the activities of twenty-five representative physicians from Minnesota and nearby states, who for two weeks studied the meaning and value of the patient-physician relationship, the normal personality development, and the significance of this development in solving problems that confront the general practitioner. Although specifically directed to doctors, this book contains much material of value to all groups for it deals with problems facing everyone today when it appears that survival of our civilization will depend on understanding and co-operation. It represents a well-planned, yet informal teaching program of detailed character which discusses problems every student of medicine and every doctor meets in everyday clinical practice.

The introduction reviews the schedule to be followed in psychotherapeutics, and the goals to be reached in the course. With the clear-cut pattern in mind, the reader is able to follow the many discussions and clinics and make better use of the valuable teaching material presented. There are chapters on history-taking, patient-physician relationship, normal personality development, psychotherapy, psychoneurosis, anxiety, life situations, emotions, and disease, and discussions of various clinical problems.

Each chapter in the book represents material which was presented to the institute of physicians by a specific instructor. Following presentation of the material, a round-table discussion was held, and relevant problems brought forward by the group. The round-table discussion is recorded at the conclusion of each chapter. A helpful index and list of suggested readings complete the verbatim recordings of these interesting and instructive weeks.

"Teaching Psychotherapeutic Medicine" stresses putting the proper interpretation on the patient's problems and aids in building the framework for understanding and accepting these problems with the proper attitude in mind. The abundant discussion, exchange of information, and questions answered by the instructors, sometimes at length and not without occasional humorous incidents, provide an interesting and valuable exhibit of teaching method. We are reminded that psychiatry has something that could and must be shared with general medicine.

Anyone who reads this book can not help but have a greater understanding of human emotions and the physical expression of emotional tension. The point is clearly made that there is a ladder of accomplishment: the first rung is interest, the second understanding, the third skill, the fourth judgment. After reading this book we should be more keenly sensitive to the needs of human beings who are sick and, as a result, we should be able to work more effectively toward their relief.

In the opinion of the reviewer this text could be used most advantageously by senior medical students, internes, and nurses, as well as by the doctor in general practice.

M.L.I.C. Nursing Service

The following are staff changes in the nursing service of the Metropolitan Life Insurance Company:

Transfers: *Madeleine Bulteau* (Ste. Jeanne d'Arc Hospital, Montreal, and University of Montreal public health course), *Mariette Léger* (Notre Dame Hospital, Montreal, and U. of M. p.h. course), and *Ghislaine St. Gelais* (Ste. Justine Hospital, Montreal) from Montreal to Quebec City.

Resignation: *Simone Cadieux* (Sacred Heart Hospital, Hull) from Montreal to be married.

In the Good Old Days

(The Canadian Nurse, January, 1909)

"A book agent visited the 400 nurses of Toronto a few months ago. His book was a wretched, useless, imposing compilation, badly printed, badly illustrated and badly bound. We declined it on sight. But the man was a good book agent. He took out of Toronto $750 of the nurses' good, hard-earned money. One hundred and fifty nurses bought a copy at $5.00 each. Moral—Never buy a book on nursing unless you have seen it favorably reviewed in *The Canadian Nurse.*"

(That is still very sound advice!)

"In considering visiting nursing in Canada, the work of the Victorian Order of Nurses must first be considered. Although the Order does not confine itself to visiting nursing, of its eighty-one nurses only thirty-one are at present doing hospital work; still it is as a visiting nursing association that it is best known. And in it we have the very great advantage of a central association . . . I have heard ardent visiting nurses, organizers of such work in the United States, wish they had some such central organization as the Victorian Order."

"The Ecole Belge—This is the first Belgian School for Nurses and is under the charge of Madame Cavell, who had three years' experience in London hospitals, assisted by two English nurses."

"Many of our surgical cases are now encouraged to eat a light meal as soon as the condition of the stomach will permit, the theory advanced being that the play of the muscles of mastication start into activity the entire system of digestion and aid in restoring the general normal condition. Where slight nausea or a distaste for food continues, chewing of gum is required."

"An Alumnae Association has been organized in connection with the Vancouver General Hospital Training School for Nurses . . . This is the first nurses' alumnae association in the province, and much is hoped for and from it."

The Annual Nurses' Service

In order to appreciate fully the significance of the service, it may be wise to re-acquaint ourselves briefly with the story of Florence Nightingale and the Rev. John Smithurst who was rector of St. John's Church in Elora, Ont., from 1852 till 1857. John and Florence were first cousins and because mid-Victorian custom forbade the marriage of cousins, they renounced their love and dedicated themselves to the service of humanity. John's ministry was to the souls of men; Florence's service was to the bodies of men though it was not by any means segregated from soul ministry. In 1839, John came to Canada and went to the Red River settlement as a missionary to the Indians. He labored faithfully there for twelve years. Later he became rector of St. John's parish. In 1852, the year in which Forence became a nurse, she sent a beautiful silver Communion Service to the parish. The Communion Set was a symbol of their sacrifice and for nearly one hundred years it has been used. Sunday, October 17, 1948, marked the third annual Nurses' Service in the Church of St. John the Evangelist which is now better known as the "Nurses' Shrine."

On entering the church we signed the guest book and, as we did so, we were able to view the Communion Service. It is now preserved behind shatter-proof glass and in a steel vault in the wall between the chancel and the vestry.

It was not long until the church was filled to capacity by nurses, most of whom were in uniform and who represented many hospitals in Districts 2 and 3 of the R.N.A.O. An atmosphere of re-dedication was created in that beautiful church by those nurses in their spotless uniforms who had come to worship. A spirit of joyful yet solemn reverence prevailed throughout the service.

Probably the most memorable part of the service was the dedication of the altar rail—the gift presented by the nurses in Districts 2 and 3. The rail is of oak and made in a simple but beautifully carved pattern. This dedication was made by the Rt. Rev. L. W. B.

Broughall, M.A., D.D., Lord Bishop of Niagara, who mentioned that the altar rail, given to further beautify and adorn the church, was a most appropriate gift since it is so closely associated with the Communion Service. The sermon was delivered by the Bishop. His main emphasis lay in the fact that nursing ought not to be looked upon merely as a remunerative profession but instead as a service to mankind which, in the final analysis, has its roots in a calling by the will of God. Our main concern in seeking to live up to our high calling ought to be in asking for grace to serve with all our ability. Ministry to patients ought to be a ministry to the soul for at the bottom of all healing is faith—in the doctor, in the nurse, and in God.

After the benediction, the congregation, which numbered over four hundred persons, remained seated while photographs were taken. Being present at that service was an experience I shall not forget.

Nursing Sisters' Association

(*Concluded from page 49*)

news that Miss Margaret Macdonald, Matron-in-Chief during World War I, was ill, saddened all. Mrs. Stuart Ramsay, at whose home twenty-two years ago the national organization was formed, was present. Miss Maude Wilkinson, a past president, was there. Pottery souvenirs and delightful menus were given to each member present at the dinner. The nursing sisters carried away with them to their various homes across Canada, to their various positions in the nursing profession, the words of their national president, particularly, as she closed her welcoming address:

"We are justly proud of our war record. May posterity record as worthy the efforts made by the Nursing Sisters' Association of Canada to work together for a lasting world peace."

British Columbia

The following are changes occurring on the staff of the Public Health Nursing Division, British Columbia Department of Health and Welfare:

Appointments: *Mary A. Dunn* (University of Alta. Hospital; U. of A., B.Sc. course in public health nursing; M.A. in public health nursing, Teachers College, Columbia University) to senior nursing position, Saanich and S. Vancouver Is. health unit; also *Ann M. Quayle* (St. Paul's Hospital, Saskatoon, and U.B.C. cert. course) to same unit; *Dorothy Kreutzer* (Regina General Hospital and McGill University p.h.n. course) Central Vancouver Is. health unit at Nanaimo. To E. Kootenay health unit: *Alison Neilans* (Royal Jubilee Hospital, Victoria) at Creston; *Mabel Gifford* (R.J.H. and University of Toronto p.h.n. course) at Cranbrook. To N. Okanagan health unit: *Gladys Carruthers* (Royal Victoria Hospital, Montreal, and University of Man. p.h.n. course) at Vernon; *Lydia Penner* (Winnipeg General Hospital and U.B.C.) at Armstrong; *Margaret Stone* (University of Alta. Hospital and U. of A., B.Sc.) at Salmon Arm. To. S. Okanagan Valley health unit at Kelowna: *Grace White* (Ottawa Civic Hospital; U.B.C. p.h.n. course; McGill University administration and supervision course); *Ruth Stratton* (Winnipeg General Hospital and University of Man. p.h.n. course). *Miriam Cressman* (Vancouver General Hospital; University of Western Ont.; U.B.C. p.h.n. course) Burns Lake district; *Catherine Spark* (Winnipeg General Hospital and U.B.C. p.h.n. course) Courtenay service; *Shirley Scanlan* (Royal Victoria Hospital, Montreal) Prince George; *Joan Davis* (V.G.H. and U.B.C. p.h.n. course) Williams Lake; *Frances Hewgill* (Winnipeg General Hospital and U. of T.) Coquitlam district; *Ruby Dunn* (Regina General Hospital) and *Ann Olson* (Royal Inland Hospital, Kamloops) Kamloops district; *Dorothy Irwin* (Victoria Hospital, London, and U. of W.O., B.Sc. in p.h.n.) and *Phyllis Harwood* (Royal Jubilee Hospital, Victoria, and U.B.C. cert. course) Abbotsford; *Irene Stewart* (University of Alta. Hospital; U.B.C. cert. course; C.M.B., Queen Charlotte Maternity Hospital, London, Eng.) Nakusp district; *June Cornell* (V.G.H.) Powell River district; *Margaret Steeves* (Royal Columbian Hospital, New Westminster, and U.B.C. cert. course) Prince Rupert health unit; *Anna*

Spence (Winnipeg General Hospital; University of Man.; B.Sc., University of Minnesota) Cloverdale; *Patricia Kahr* (Royal Victoria Hospital, Montreal, and U.B.C. cert. course) Mission district. *Joyce Leslie* has returned to staff as senior nurse with Prince Rupert health unit.

Transfers: *Dorothy Paulin*, senior nurse, Saanich and S. Vancouver Is. health unit, as public health nursing supervisor from central office, Department of Health and Welfare; *Nan Kennedy* to senior position in Chilliwack area from Rossland district; *Marion Bellis* from Saanich and S. Vancouver Is. health unit at Sidney to Ashcroft; *Margaret (Abernethy) Winch* from E. Kootenay health unit at Cranbrook to Courtenay service; *Doris Vosburgh* from Nakusp district to Fernie; *Margene Clarke* from Saanich and S. Vancouver Is. health unit to Enderby in N. Okanagan health unit; *Joan Appleton* from Ashcroft district to West Summerland in S. Okanagan Valley health unit; *Kay Comerford* from Trail-Rossland district to Castlegar; *Olive Johnson* from Prince Rupert health unit to Sidney in Saanich and S. Vancouver Is. health unit; *Janet Pallister* from S. Okanagan health unit to senior nurse position in Cloverdale; *Kay Read* from Peace River health unit to new district of Windermere-Golden; *Alice Heron* from N. Okanagan health unit at Vernon to Division of T.B. Control, Victoria; *Doris Barish* from Coquitlam district to Division of V.D. Control, Vancouver.

Resignations: *Madeline Lerty* and *Iris Bothamley* to study at University of Oregon; *Evelyn Tier* from Trail-Rossland service to continue studies in New York; *Joan Ciceri* and *Suzanne Harrison* from Central Vancouver Is. health unit, the latter to be married; *Ada George* from Creston district of E. Kootenay health unit to continue studies at U.B.C.; *Mary Grierson* from Mission service; *Barbara Smith* from Prince Rupert health unit to take p.h.n. supervision at U. of T.; *Miriam Moran* and *Margaret Campbell* from Kamloops district, the latter to enrol in School of Public Health, Ann Arbor, Mich.; *Audrey Ward* and *Isabelle Irwin*, the latter to be married.

Canadian Red Cross

The following are staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia: APPOINTMENTS — *Florence M. Erickson* (St. Luke's Hospital, Spokane) as assistant supervisor, outpost hospitals, B.C. Division; *D. A. Popow*, (Yorkton General Hospital) as matron and *Jane P. Marshall* (Warkoto Hospital, New Zealand) to McBride; *Georgie C. Robb* (Toronto General Hospital) and *Mrs. Frances Perry* (T. G.H.) to Terrace; *Irene Cowan* (Royal Infirmary, Edinburgh) as nurse in charge at Blue River; *Anne D. Mansell* (Victoria Hospital, Prince Albert, Sask.) as nurse in charge at Lone Butte. RESIGNATIONS — *Christine Campbell* as assistant supervisor, outpost hospitals, B.C. Division; *H.O. Mann* (Amasa Wood Hospital, St. Thomas) and *Mary E. Harris* (St. Joseph's Hospital, Hamilton) from McBride; *Mrs. Van Maurik* (Wilhelmina Hospital, Amsterdam) to take a post-graduate course, *Mary E. Piper* (St. Bartholomew's Hospital, Eng.) to return to England, *Mrs. F. B. Sikler* (Regina General Hospital), and *Mrs. M. Mackay* (St. Joseph's Hospital, Victoria) all from Terrace.

New Brunswick: APPOINTMENTS — *Marjorie A. Hudson, B.Sc.N.* (Royal Victoria Hospital and University of Western Ontario), director, nursing services, N.B. Division; *Helen Mae Hamilton* (J. H. Dunn Hospital, Bathurst) and *M. Eleanor Kennah* (Halifax Infirmary), Miscou-Shippegan Islands; *Olive Keswick* and *Mary Kingston* (Saint John General Hospital), Rexton; *Marion Hawthorne* (Fisher Memorial Hospital, Woodstock), Plaster Rock; *Patricia Knorr* (Chipman Memorial Hospital), Harvey. RELIEF — *Emma Cunningham* and *Frances Weston* (Royal Victoria Hospital), Harvey; *Alice Walker* (Royal Victoria Hospital), Plaster Rock; *Mrs. Catherine Burgess* (Hotel Dieu, Moncton), Rexton; *Doris Richardson* (Chipman Memorial Hospital), Grand Manan. RESIGNATIONS — *Harriett Hughes* from Rexton; *N. A. Cooney* from Plaster Rock.

Ontario: Returned from post-graduate study in public health nursing at University of Toronto — *Ruth Boskill* to Apsley, *Elsie Turner* to Wilberforce, *Betty McIntosh* to Dryden, *Margery Rilett* to Atikokan. APPOINTMENTS—*Mary Young* (Wellesley Hospital) and *Muriel Depencier* (Hamilton General Hospital) to Thessalon; *Rita Roberts* to Bracebridge; *Mrs. Marion Whitman* and

Della Scott from the Maritimes to Thessalon; *Patricia Hart* (Lightbourne Hospital, Glasgow) to New Liskeard; *Jessie McCully* (Timory, New Zealand) to Englehart; *Amy Hayward* and *Elizabeth Leigh* (Ottawa Civic Hospital) are relieving until the new Nipigon Hospital is ready.

Certified Nursing Assistants now on duty as follows — *Anna McKinnon* and *Olive Rousseau* to Bracebridge; *Pearl Robinson* and *Alta Bullock* to Dryden; *Josephine Jerry* to Emo; *Patricia Cronen* to Espanola; *Anne Vasilovitch* to Hawk Junction; *Bernice Byford* to Hornepayne; *Colletta Walsh* to Thessalon; *Mildred Johnston* (Presbyterian Hospital, N.Y.) relief work at Englehart.

RESIGNATIONS AND LEAVES OF ABSENCE— Marriage or preparation for the event accounted for the following resignations: *Lloydia Orr* and *Elsie Jenner* from Beardmore, *Letitia Scott* from Emo, *Jean Claridge* from Nakina, *Mrs. Winnifred (Singleton) Macdougall* from Red Lake, *Margaret Chattoe* from Wilberforce. To take post-graduate study — *Gloria Graschi* from Bracebridge to study in surgery, *Dorothy Hall* on a Red Cross bursary for hospital administration and *Dorothy Morgan* on a provincial Department of Health bursary from Hawk Junction to university at London; *Wilma Lippert* from Haliburton on a Red Cross scholarship to take public health at University of Toronto; *Bernadette McGarity* from Rainy River and *Ruth Weekes* from Atikokan for further study.

ADDITIONAL RESIGNATIONS—*Leah Griffiths* from Bracebridge; *Aldene Fitzgerald, Irene Sellers,* and *Effie McKeachnie* from Dryden; *Anna Wall* from Emo; *Mary Anderson* from Lion's Head; *Moira Hazlett* from Red Lake and *R. McDiarmid* from Richard's Landing.

TRANSFERS — *Beryl Rowntree* from Espanola to charge nurse at Dryden; *Yvonne Card* from Apsley to Englehart; *Hazel Ball* from New Liskeard to Lion's Head; *Donna Thompson* from leave of absence to Mindemoya; *Barbara Easton* to relieve at Nakina and *Geraldine Garnett* from New Liskeard to Nakina; *Louise Grover* from Bracebridge to Rainy River; *Janie MacEwen* and *Lila Robbins* from Mindemoya to Red Lake; *Dorothy LeGrow* from Englehart to Thessalon.

Quebec: APPOINTMENTS — *Mrs. Haidee Pearce* (City of Sydney Hospital) to Entrée Is. nursing station, Magdalen Is.; *M. Berthe Boucher* (Sacred Heart Hospital, Quebec) to Grand Entrée nursing station, Magdalen Is. RESIGNATION — *Marie Ford* from Grosse Isle nursing station, Magdalen Is. TRANSFER — *Dorothy Keith* from Barachois to Grosse Isle, Magdalen Is.

Saskatchewan: APPOINTMENTS — *M. Williamson, C. Curtis,* and *E. Radke* to Hudson Bay; *Mrs. Lamsdown* to Arborfield; *Mrs. C. Hoye* and *S. Caharel* to Leoville; *Mrs. A. Cheleberg* (Lellehammer, Norway) to Pierceland. RESIGNATIONS — *R. Dulmage* from Paddockwood; *E. Hockley, M. Jones* from Hudson Bay; *P. Mitchell, S. Saxon* from Leoville; *V. Ollis* and *R. Thomas* from Loon Lake.

Ontario

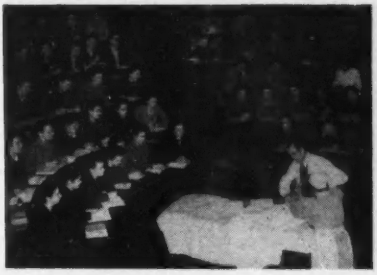
The following are recent staff changes with the Ontario Public Health Nursing Service:

Appointments: *Clara M. Noseworthy* (St. John's General Hospital, Nfld. and University of Toronto cert. course), Middlesex County school health service; *Christian Watt* (Falkirk Royal Infirmary, Scotland, and Edinburgh University public health course), North Bay board of health; *Mrs. Mary Fraser* (University of Iowa School of Nursing and U. of T. cert. course), Peel County health unit; *Ila Wood* (Peterborough Civic Hospital and U. of T. cert. course), Prince Edward County health unit; *Minnie Bushfield* (Hamilton General Hospital and U. of T. cert. course), formerly with Guelph board of health to Kitchener board of health; *Mary Lankin* (H.G.H. and U. of T. cert. course), formerly with United Counties health unit to Hamilton Department of Health nursing staff; *Burma Morlock* (St. Joseph's Hospital, London, and University of Western Ont. cert. course), York Township board of health; *Mrs. Mabel Hatcher* (Victoria Hospital, London, and U. of W.O. cert. course), as director, public health nursing, London Board of Health, succeeding *Cora Taylor* who has retired.

More Indians live in British Columbia than in any other province. There are 25,515—one-fifth of the national total.

An Editor's Dilemma

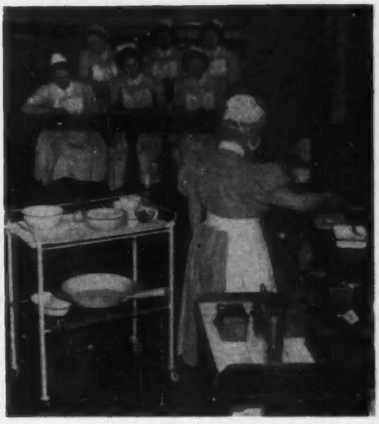
Once upon a time, to wit, the November, 1948, issue (p. 900), there was an interesting story of the "study days" program in the schools of nursing in England. To add to the reader interest, the cuts for three illustrations were prepared to accompany this article. Then, gremlins or printers' devils or some other mischievous sprite, buried those illustrations so effectively that the *Journal* had gone to press before they were unearthed. Now the problem was—what to do with the pictures? So, rather than scrap them, we are running them herewith. Actually, the captions tell the whole story, so it will not even be necessary for you to find your November issue to complete your information.



Dr. Charles Donald taking a clinical class in the Bearstead Theatre of the London Hospital.

Dr. Valentine conducting a bacteriology class.

Photos by Topical Press



Miss Harris, sister tutor, demonstrating the preparation of a trolley for sterile dressings.

News Notes

ALBERTA

LAMONT:

Joan Graham was re-elected president of the Lamont Hospital School of Nursing Alumnae Association at its 17th annual meeting. The vice-presidents are Mmes A. Southworth and A. Lentz. The secretary-treasurer is Mrs. B. I. Love. Serving on the various committees are: J. Ferguson, V. Alho, Mmes A. Cowan, H. MacPherson, R. Shears, R. Wood, D. Yuskiw, J. L. Cleary, C. Craig.

Several clauses in the constitution were discussed and revised. Consideration was also given to the Scholarship Fund. This scholarship is available to a graduate of the school of nursing. The fund may be used for post-graduate work in any school or college of the applicant's choice; the sole requisite is a university entrance diploma. The only stipulation is that, on her return, the recipient work for a year in any hospital or training school in Alberta. In her secretary's report for the past year, Mrs. Love commented on the fact that, since the hospital school opened in 1915, 251 nurses have graduated and that 69 are paid-up members of the alumnae.

At the dinner, following the meeting, the members were pleased to have as their guest speaker Madeline McCulla, assistant director at the University of Alberta School of Nursing. In her address Miss McCulla remarked that the graduate nurse's first professional relationship begins when she becomes a member of the alumnae of her training school and, through it, contacts are made with other professional organizations.

The toast to the Alma Mater was proposed by Mrs. E. Bryks and replied to by M. Mapletoft. The newly-appointed superintendent of nurses, L. Marie Young, was introduced by the president.

A travelogue, "From Paris to India with the Imperial Oil," was later shown to the members and their guests.

BRITISH COLUMBIA

ABBOTSFORD:

At a recent meeting of Matsqui-Sumas-Abbotsford Chapter, when twenty-two members were present, Joyce Coulson, Home Service Adviser for the B.C. Electric Co., showed interesting films on "Home Lighting" and "Kitchen Magic." Another highlight of the meeting was the presentation to Miss Ellis, matron of M.S.A. Hospital, of an engraved sterling silver spoon from the chapter members. Miss Ellis leaves to take a new position in Alberta.

A party is to be given for high school girls for the purpose of interesting them in nursing. It was reported that a food parcel was sent overseas to a needy nurse in time for Christmas.

Chapter members attended a Christmas party given by the Senior and Junior Hospital Auxiliaries. An article of used clothing or preserved food was brought by each person to be used for hampers for needy families.

CHILLIWACK:

F. Orton, vice-president, presided at a recent meeting of Chilliwack Chapter. Discussion centred around parcels for overseas and the child "adopted" through the Save the Children Fund. It was decided to send a parcel to L. Hodgkins, former matron of the General Hospital, until the members had more definite news about their "adopted" child. Mrs. Barwell gave a report from the Local Council.

An article on "Baltic Refugee Girls Begin Nurses' Training in Holland" was read by Mrs. Rowberry and "Annuities for Nurses" was the title of a paper read by A. McKay.

In November the Coqualeetza Hospital at Sardis was badly damaged by fire. Doctors, nurses, and staff should be commended on the way in which they evacuated 150 patients in twenty minutes.

KAMLOOPS-TRANQUILLE:

E. L. Stalker, delegate of the Kamloops-Tranquille Chapter to the district meeting held in Penticton, returned with an informative account of the activities of the Kamloops-Okanagan area. The autumn meetings included an entertaining talk by Mrs. L. Shead, the nurse at the Indian agent's office, on her progress among the natives in prenatal, post-natal, and immunization work. J. Phillips also gave an account of her impression of the British Isles which she visited recently.

Donations from the chapter include: United Emergency Fund for Britain, $100; Netherland nurses, $30; parcels for nurses in Britain, $50. Used uniforms are being packed by the members for shipment to nurses in Korea.

PRINCE RUPERT:

At a recent meeting Olga Sather was elected president of the Prince Rupert Chapter. Miss Steeves will serve as vice-president, Edna Dobbie, secretary, and P. M. Mooney, treasurer. Interesting moving pictures were shown by Miss Mooney following the business session. Regular meetings are held on the first Monday of each month.

MANITOBA

BRANDON:

Four nurses provided an interesting meeting for the Brandon Association of Graduate Nurses when they spoke to the members recently. Lillian MacKenzie, director, city health nursing division, Winnipeg, gave reports of the C.N.A. convention in Sackville, also mentioning the establishment of the Metropolitan School of Nursing at Windsor. Mary Wilson, senior nurse with the Selkirk health unit, gave an account of the biennial convention social events. Mrs. B. A. Bennett, O.B.E., chief nursing officer with the British Ministry of Labor, gave a paper on some interesting aspects of nursing. Bertha Pullen, superintendent of nurses at the Winnipeg General Hospital, was the final speaker. Her talk dealt with the importance of good public relations. The guests were introduced by Elizabeth Russell, director of public health nurses, Manitoba Department of Health and Public Welfare, and thanked by Margaret Gemmell. The president, C. Wedderburn, was in the chair.

At a regular meeting of the association reports from the various conveners showed considerable activity. Mrs. Peirce told of an active summer program in sending food parcels to England. A successful tea and sale of home cooking was reported by the married nurses section and the cancer tag day was also a success. The Scholarship Committee appointed a member from each group to act with it during the coming year. A social hour followed when Mrs. M. Mills and her group served refreshments.

WINNIPEG:

Children's Hospital:

The annual meeting of the alumnae association was held in the form of a dinner when the yearly reports were given by the various conveners and the election of officers took place. The president is Mrs. Andrew Bruce with Mrs. F. G. Prest serving as vice-president. E. Clark is secretary while V. Davis will serve as corresponding secretary and Mrs. H. K. Davis, treasurer. Various committee conveners include: Mmes A. J. Noble, C. Mitchell, J. C. Kirby, H. W. Moore, C. D. Barber.

Winnipeg General Hospital:

Dr. and Mrs. A. G. Henderson (Allison Jamieson) are returning from the Belgian Congo for a year. (See Dec. issue, p. 1008.)

Merle Graham is on the staff of the Florence Crittenden Hospital, Detroit.

NEW BRUNSWICK

SAINT JOHN:

The Lancaster Nurses Association were hostesses at a recent meeting of Saint John Chapter when the president, Bessie Seaman, was in the chair. The usual business was conducted with Councillor Edna Steele explaining the work of the Local Council of Women. An interesting address was given by Mr. T. C. MacNabb on the United Nations Society. K. Bell and M. Carey were named conveners of the nominating committee in preparation for the annual meeting in January.

General Hospital:

Phyllis Fraser, a Vancouver General Hospital graduate who has been practising in Saint John, was entertained by Isabel Richardson prior to her return to Vancouver. Mrs. Helen Henderson, a Rhode Island Hospital graduate, is now on the staff as assistant instructor.

St. Joseph's Hospital:

A satisfactory attendance at a recent alumnae meeting made the Bring and Buy Sale very successful. The Crastinus Credit Union Ltd. held its 13th annual meeting at the home of the president, Mary Downing. Reports showed a successful year and dividends were declared. The "Crastinus" was the first women's credit union to be formed in the province and is composed of nurses.

Zeta Parsons is now on the staff of St. Clare's Hospital, New York, and Florence McGinnes is also there serving with the Presbyterian Hospital.

NOVA SCOTIA

HALIFAX:

Victoria General Hospital:

The massive stone and brick structure of the new Victoria General Hospital has the general floor outline of an aeroplane — a central rotunda with three wings extending north, south, and west. Special care has been taken to give the hospital an atmosphere of homelike comfort and tranquillity.

N.S. Bureau of Information

Victoria General Hospital

The hospital is 15 storeys high in gradually receding dimensions. Of the total capacity of 400 beds, the 250 public ward beds are divided into 10- and 12-bed wards on the 4th, 5th, and 6th floors. The 7th and 8th floors contain 80 private rooms and 70 semi-private. To avoid monotonous uniformity, the wards have been kept small, some of them being angular in shape. No adjoining wards are decorated the same, a variety of pastel tones having been used with matching floral drapes. Bed-spreads and slip-covers blend in color with the wall tones.

At the end of each floor is a large glass-enclosed solarium. Here the hangings are in gay colors and the reclining easy chairs and writing desks add to the comfort of the ambulant patients. In the wards and semi-private sections there are also "quiet rooms" for patients whose conditions require segregation. These rooms are separated from the wards by glass panels, permitting staff members to keep patients under observation at all times.

The x-ray unit is located on the 3rd storey of the west wing and contains the most up-to-date equipment. In the north wing is the physiotherapy and occupational therepy department. On the 12th floor there are five general operating-rooms and three for specialized surgery.

As protection against entry of impure air of varying temperature, the operating-rooms are without windows. Special lighting is provided by lenses and mirrors which make it possible to direct light in such a manner that no shadows are cast where the operation is being performed.

From the central supply room situated on the 12th floor runs a system of pneumatic tubes carrying supplies to all parts of the hospital. Records of orders can also be sent to different sections through this medium.

Since the hospital is T-shaped and the desk of the floor supervisor forms a half-circle at the junction of the T, efficient supervision is possible at all times. From this station there is an unobstructed view to the remotest end of the corridors.

All buildings are linked by an underground tunnel system, some 800 feet in all, extending from the main building to the old hospital, nurses' residence, pavilion, boilerhouse, laundry, and the pathological building. This system facilitates transportation of patients, equipment, or stores.

The out-patient department, occupying most of two wings on one floor, will provide expanded service to the general public. Primarily designed for the diagnosis and treatment of ambulatory patients who need follow-up care, it will also afford treatment to those patients needing hospital attention, but whose condition does not necessitate hospitalization. Arrangements are made to conduct a number of departments, each dealing with a different branch of medicine.

The auditorium on the ground floor has a seating capacity of 275. It will be used as a teaching and clinic room.

The presentation of a memorial painting

by the members of the nurses alumnae association was made at a regular meeting. This painting is in memory of Lieut. (N/S) Jessie Margaret MacLeod, the only alumnae member to lose her life in W.W. II. The superintendent of the hospital, Dr. C. M. Bethune, and Rev. W. S. Dunlop paid tribute to the nursing sister. A 1927 graduate of the hospital, Miss MacLeod was a native of Pictou Co. Enlisting at the outbreak of war, she died on service with the Eastern Air Command in April, 1941. The painting, a seascape of Blue Rocks, Lunenburg Co., is by a young Nova Scotian artist, Joseph Purcell, and may be seen in the rotunda of the hospital.

Presenting the painting to Victoria General Hospital — left to right: Dr. C. M. Bethune, Mrs. H. S. T. Williams, Rev. W. S. Dunlop.

1948 INDEX

SUBSCRIBERS WISHING TO RECEIVE COPIES OF THE

1948 Index

ARE REQUESTED TO COMPLETE THIS COUPON AND MAIL IT TO:

THE CANADIAN NURSE

Suite 522 — 1538 Sherbrooke St. W.
MONTREAL 25 QUEBEC

Name.....
(Please Print)

Street Address.....

City..... **Prov.**.....

Number of copies desired.....

The presentation was made by Mrs. H. S. T. Williams, who was the convener of the committee to select the painting. The committee consisted of: C. Patterson, L. Creaser, E. Atkinson, M. Griffith, and Mrs. J. Luscombe.

ONTARIO

District 1

CHATHAM:

Awarding of the first life membership in the alumnae association of the Public General Hospital to a former president, Annie Head, was greeted with enthusiasm by some 130 graduates attending the 27th annual dinner meeting.

LONDON:

The annual educational program of the Community Nursing Registry recently featured a series of six talks by London doctors on various phases of nursing care and medical treatment. St. Joseph's Hospital was the scene of the lectures.

The subjects were as follows: Nursing care of the urological patient (Dr. E. D. Busby); heart catheterization and obscure heart conditions, with film (Dr. J. A. Lewis); neurosis (Dr. H. B. McNeel); blood chemistry, with mimeographed notes (Dr. E. M. Watson); nursing care of chest, and of thyroid patients (Dr. F. S. Kennedy); modern surgery (Dr. A. D. McLachlin).

All registered nurses in the district were eligible to benefit from this program. The Educational Committee was convened by Gertrude Clarke of Victoria Hospital. Also on this committee were R. Rouatt, Mary Beattie, and Dr. DeW. Wilcox, assisted by Margaret Stevenson, president of the Registry Board.

District 4

HAMILTON:

Anna Oram, district chairman, presided at a recent quarterly meeting when more than 120 graduate nurses were in attendance. A helpful and stirring address on "The Challenge of Nursing" was given by Dr. W. J. Deadman, pathologist of the city of Hamilton. He emphasized the importance of organization among nurses in order that the services of the nursing profession might be of greater value and of better quality. He was introduced by Edith Bingeman.

Margaret Blackwood, with the assistance of Sr. M. Ursula, C. E. Brewster, H. Snedden, and B. Key, conducted an interesting discussion on some of the highlights of the C.N.A. convention held at Sackville.

Tea was served after the meeting, with Mrs. B. L. Markle, president of St. Joseph's Hospital Alumnae Association, in charge.

District 5

TORONTO:

St. Michael's Hospital:

Sr. Louise has been appointed superior and superintendent of St. Joseph's Hospital, Toronto. She was formerly bursar and later assistant superior and assistant superintendent at St. Michael's. As a token of appreciation and respect, a travelling clock was presented to Sister on behalf of the alumnae members. Sr. Maura, who succeeded Sr. Louise as bursar in 1945, is now assistant superior and assistant superintendent.

Sr. Mercedes celebrated her Golden Jubilee in the Community of the Sisters of St. Joseph last August. It will be remembered that a few years ago Sister celebrated her Golden Jubilee as a graduate of St. Michael's.

Margaret Sherman, who served with the health service department for thirteen years, has been appointed to Runnymede Collegiate by the Department of Health. A farewell tea was given in her honor and F. Conlin entertained at her home for Miss Sherman when a "Parker 51" was given to her by her associates at the hospital. C. McGuinness succeeds Miss Sherman.

Recent hospital appointments include: Sr. Florian, out-patient department; Sr. St. Albert, now a member of the C.N.A. Executive, 4D; Sr. Berniece, emergency department; Sr. Loretto, 3B; Sr. Helen Marie, 3C; A. McNamara, 1D; Sr. de Sales, who received her degree at St. Louis University, nursing arts instructor; B. McKenna, formerly with Toronto V.O.N., teaching staff.

Other appointments are as follows: Sr. Stanislaus to Our Lady of Mercy Hospital, Toronto, from St. Joseph's in Winnipeg; Sr. Evangelista to St. Joseph's, Winnipeg, from St. Joseph's in Comox; Sr. Marion to St. Joseph's Hospital, Toronto, in charge of O.R.; Sr. St. Neilus as nursing arts instructor, St. Joseph's, Toronto; B. Snider, to St. Joseph's, Peterborough; Ann Dolcini as superintendent, Alamosa Hospital, Colorado; M. McGarrell, formerly on clinical supervision staff, Toronto General Hospital, as nursing arts instructor, Ottawa Civic Hospital; G. Donovan, formerly with teaching staff at St. Michael's, to Yorkville district of Toronto Public Health Department; Esme Murphy and Lina Costa to Stormont, Dundas and Glengarry health unit; Lucille Bonin, of the Toronto Public Health Department, to East End Division; Betts (Marchand) LeMay to Simcoe County health unit; Elaine Hopkins to Toronto V.O.N.; Marie Evers and Gwen Ferguson to Toronto Department of Public Health; Stella Goodrow, M. Shepherd, and F. Sylvain to St. Elizabeth Visiting Nurses' Association; M. Nealon to Christie St. Hospital.

The following are resignations: Helen Keaney, on the staff of St. Elizabeth Visiting Nurses' Association for the past twenty-two years, now doing general duty at Our Lady of Mercy Hospital; L. Riley from Leeds and Grenville health unit.

Joan Hope has been awarded a scholarship in public health nursing by the St. Elizabeth Visiting Nurses' Association and is at U. of T. Srs. Mary Brigid and Marie Antoinette are also at U. of T. E. Gillis has been awarded a Department of Health bursary. M. McGarry is taking public health at U. of T. M. Meehan is at the Royal Victoria Hospital, Montreal, for a neurosurgery course.

Congratulations are extended to the Sisters of St. Joseph, Pembroke, on the opening of their new hospital at Radville, Sask. Rev. Mother Magdalene is in charge. Four sisters of the same community are now in training at St. Michael's — Srs. Hedwig, Jeanne, Marjorie, and Lois.

Recent visitors to the school include: M. Powers, Niagara Falls; M. Quinn, Long Island, N.Y.; A. Gaudet, Dearborn, Mich; J. Harrington, Oakland, Calif.; N. Murphy, Winnipeg; Mrs. T. Stahre, Calif.; and H. McMahon and E. Baldwin.

District 7

SMITHS FALLS:

Approximately 125 nurses attended a recent meeting of District 7 when, in spite of a heavy fog, Kingston, Napanee, Brockville, Gananoque, Perth, and Smiths Falls were all well represented. Miss Corbett, of Brockville, the president, was in the chair. After routine business, Amy Church introduced the guest speaker, Mr. Ernest Benton of the Stevens Co. Mr. Benton, W.W. II veteran and a graduate of a special course in hospital engineering, presented an illustrated lecture on "Sterilization and Aseptic Technique." Two films were shown on operating-room technique as given at the Peter Brent-Brigham Hospital, Boston. Miss Purcell thanked the speaker.

Refreshments were served by Mrs. Flegg and her helpers.

BROCKVILLE:

Geneva Purcell, chairman of Brockville Chapter, presided at the first meeting of the season, when thirty members were present. Means of raising funds for the District Bursary Fund were discussed. It was decided to hold a Valentine tea and bazaar for this purpose. An enthusiastic discussion took place regarding a refresher course to be sponsored by the chapter. Mrs. Orr, superintendent of nurses, Ontario Hospital, and Miss Purcell, superintendent of nurses at the General Hospital, gave interesting reports of the C.N.A. biennial convention. They attended the meetings as representatives from the chapter.

District 8

OTTAWA:

Annetta Landon, chairman, presided at a recent meeting of District 8 when interesting reports were presented by nurses attending the C.N.A. biennial convention. Those taking part were: Frances Harris, Dorothy Percy, Juliette Robert, and A. Grieve. Plans were also discussed for the R.N.A.O. annual meeting to be held at the Chateau Laurier in April.

A skit was presented by members of the staff of the Civic Hospital.

On the occasion of her retirement as chief superintendent of the V.O.N., Maude Hall was guest of honor at a dinner given by the executive of District 8.

Frances C. Harris is now a nursing councillor with the Civil Service Health Unit, Department of National Health and Welfare. Her former position was consultant in industrial nursing in the Division of Industrial Hygiene of the Department.

Ottawa General Hospital:

Margaret T. Phillips is on the staff of the Civil Service Health Unit, Department of National Health and Welfare, as a nursing councillor. Previously she was epidemiologist with the Ottawa City Health Department. Obtaining her public health nursing certificate from McGill, she was on the staff of the V.O.N. and then enlisted with the R.C.A.M.C.

Henedine Bechard is now epidemiologist with the Ottawa City Health Department.

For four years superintendent of St. Mary's Home, Ottawa, Miss Bechard was also on the visiting nurse staff of the Baby Health Centre, Ottawa City Health Department.

The following sisters of the Grey Nuns of the Cross are taking nursing education and supervision at l'Institut Marguerite d'Youville, Montreal: Srs. St. Honorine, St. Paul, St. Adele, and St. Charles Borroneo. The following are taking public health nursing at Ottawa University School of Nursing: L. Gendron, E. Marc, B. McCoy. Sr. M. Leonelle and Joan Stock have received their B.Sc.N. degrees from Ottawa University.

St. Luke's Nurses' Alumnae:

Many out-of-town doctors and nurses were present at a recent reception, given by St. Luke's nurses' alumnae association, to celebrate the 50th anniversary of the founding of St. Luke's General Hospital. Dr. H. B. Moffatt paid tribute to Miss Maxwell, former superintendent of nurses, and the staff of old St. Luke's. Receiving with Mrs. W. H. Brown, the president, were Emily Maxwell, O.B.E., Beatrice Rumsey, and Mary Nelson. In charge of arrangements were: Mmes W. H. Brown, J. C. MacFarlane, Misses M. J. Ross, and Norma Lewis.

DISTRICT 10

Sixty members attended a recent dinner meeting in Fort William when Edna L. Moore, director, division of public health nursing, Ontario Department of Health, was the guest speaker. Her topic was "Nursing as a Community Service." In her talk Miss Moore stressed the fact that, to give this service, we must be concerned with nursing education.

QUEBEC

MONTREAL:

St. Mary's Hospital:

M. DesRosiers is the president of the alumnae association for the coming season. The vice-president is Mrs. T. Robillard with M. McKay and Mrs. K. Desmarteau serving as recording and corresponding secretaries. The treasurer is M. Barrett. Other members serving on the various committees include: M. Harford, L. Martin, D. Sullivan, J. Doyle, E. Sinel, and Mrs. L. Gogarty.

At a recent meeting, E. O'Hare and M. Smith gave a report on the C.N.A. biennial convention held at Sackville. An emergency fund for sick nurses was discussed, as were the annual card party and informal dance to take place early this year.

The annual communion breakfast proved a big success and the attendance was the largest in many years. Rev. Father Alex Carter said Mass while Rev. Father Emmett Carter gave an interesting talk on "Propaganda and its Effects on the Individual and the Masses."

QUEBEC CITY:

Jeffery Hale's Hospital:

E. Frances Upton, secretary-registrar, A.N.P.Q., gave a stimulating talk entitled "Nursing Situations of the Day" at a recent

alumnae meeting. The proceeds of the successful alumnae bridge will go towards the general funds of the association.

SASKATCHEWAN

HUMBOLDT:

A membership tea for the graduate nurses of Humboldt Chapter was held recently when the program consisted of a puppet play, songs by the student nurses, and musical selections. Refreshments were served by the preliminary students.

MOOSE JAW:

Lyle Creelman and Dr. Baillie, who are conducting a survey of public health facilities across Canada for the Canadian Public Health Association, paid a visit to the Regional Health Office. Dorothy Code, who has completed the advanced courses in public health nursing and administration and supervision at University of Toronto, is now senior nurse with Health Region 6.

General Hospital:

June Brown and Mrs. G. McLaughlin are on the general duty staff. Mrs. R. Clarke and Mary Brittin have resigned, the latter to go to the Municipal Hospital, Grande Prairie, Alta.

NORTH BATTLEFORD:

The following officers are now serving for the chapter: Honorary president, Sr. Superior; president, Mrs. P. Baldwin; vice-presidents, M. Richardson, Mrs. G. H. Orr; secretary, L. Boyd; treasurer, Miss Bonderoff.

The nurses assisted in the opening of the new wing of the Notre-Dame Hospital. Another project was a recent dance, the funds from which went towards the furnishings for a room in the new wing.

Mrs. B. McDonald's home was the scene of a party in honor of three nurses of the staff of N.D.H. who left to be married. They were Jean Ayers, Betty Nelson, and Irene Roy. A. W. Mullaney is taking a course at the Menegar Clinic, Topeka, Kansas. E. Edworthy is studying at McGill School for Graduate Nurses.

REGINA:

The program for a recent meeting of Regina Chapter, District 7, was provided by the Public Health Committee. This was a panel discussion outlining the work of the various nursing groups in the public health field, and showing how preparation for public health nursing work is integrated into the basic student education program. Those taking part were: C. Maddaford (chairman), senior nurse, V.O.N., Regina, who also outlined the work of that organization; E. Smith, director of nursing services, Saskatchewan Department of Public Health; G. McDonald, supervisor of nurses, Regina Health Department; M. Storey, provincial supervisor, Junior Red Cross; E. James, director of education, Regina General Hospital School of Nursing.

General Hospital:

The alumnae association recently held a successful bazaar and tea. A very welcome feature was a table of needlework, contributed by R.G.H. staff members, under the convenership of Mrs. E. Shannon.

New staff members include: B. C. Howatt, L. E. Luedtke, A. V. McKinnon, J. MacMillan, and A. Dodds.

Grey Nuns' Hospital:

Sr. Lefebvre, director, Institut Marguerite d'Youville, Montreal, recently conducted a series of staff conferences. New staff members include: B. Cantalope, M. J. Bernston, F. Szostak, C. R. Heller, M. C. McKinney, D. M. Torguson, P. Quinn (assistant dietitian), Miss Nomura, Mrs. McIsaac.

Medical Arts Clinic:

Evelyn Wade has joined the staff as librarian. She took a course at Hotel Dieu, Kingston, and recently became a member of the Association of Medical Record Librarians. L. Robinson, C. Van Allen, and G. Aadland, the latter recently with the Edmonton Clinic, are now on the nursing staff. Jean Cumine has resigned while Hilda Thompson left to take a post-graduate course at Children's Memorial Hospital, Montreal.

Public Health Nursing Staff:

Mrs. H. A. Fletcher, who was acting as senior nurse, Weyburn region, has now assumed the duties of supervisor. Mrs. D. Jardine replaces her in the region. A. Normandin has been appointed acting senior nurse, Assiniboia region. J. Walz, certified nurse-midwife, has been appointed to the staff and is relieving at Buffalo Narrows. E. M. Earnshaw and F. Kelm are situated in Tisdale and Yorkton districts. Mrs. J. Cockburn is doing public health nursing at Snake Lake, a settlement in the far north. A. MacDonald, Humboldt, and D. Brown, Assiniboia region, have resigned. M. P. Edwards, supervisor, has returned from a holiday in England.

The following are on leave of absence to take a public health nursing course: R. M. Anton (University of Man.); J. Cloarec, P. Graham, J. McIntyre (McGill University); O. Mitchell (University of Alta.); T. Edwards (University of B.C.). L. Miner and I. Langstaff are completing the degree course in nursing at McGill.

SASKATOON:

A recent guest speaker at a meeting of Saskatoon Chapter was Dr. Hilda Neatby of the History Department, University of Saskatchewan. Dr. Neatby's subject was "The United Nations."

City Hospital:

The graduate staff recently entertained the medical staff and their wives at a Harvest Hoedown. Mrs. H. L. Wilson and B. Fleming convened a successful tea held by the alumnae association. Mrs. J. E. Porteous, honorary president, and M. R. Chisholm, pre-

sident, received the guests. The proceeds will go towards food parcels to British nurses.

Mrs. Alex (Ames) Esson, formerly director of nursing, recently returned from Europe. Mrs. Esson was one of six women chosen from Canada to represent the Department of Labor in choosing displaced persons for Canada. New staff members include: Mmes S. Bigelow, D. Messner, L. Gunther, P. McIntosh, M. Mouland, Misses V. Dick, O. Fitzgerald, E. Pearson, A. Sokol, P. Young. Joyce Young is working with the T.B. ward at Sunnybrook D.V.A. Hospital, Toronto.

St. Paul's Hospital:

The Sodality sponsored a Penny Carnival which proved most successful and gave joy to many children. Dr. D. M. Baltzan addressed the student nurses on his trip to Europe and discussed problems experienced by nurses there. Dr. R. H. MacDonald, president, medical staff, addressed 3rd year students on "The Responsibilities of the Nurse in Relation to the Medical Profession."

D. Martin and A. Sedmak were welcomed on their return from the States where they took a course in obstetrics. L. Brown has completed post-graduate work in pediatrics in Montreal and is remaining in the east. New staff members include: Mrs. F. V. Cross, P. McPherson, and A. Wolf.

Saskatoon Sanatorium:

New staff members include: Mmes J. Fead, H. Montgomery, Z. Heiser, and Miss W. Huget. Mrs. Etta J. Wice has resigned.

YORKTON:

Mr. Tallant, a Yorkton Collegiate history teacher, was the guest speaker at a meeting of Yorkton Chapter, District 4. His subject was "The United Nations Effort." Mrs. A. Petcoff, chapter president, has resigned her position on the laboratory staff in order to complete the technicians' course offered at Calgary. Miss Wagner, vice-president, is replacing Mrs. Petcoff in the meantime.

A. Gwilliam, O.R. supervisor, General Hospital, has resumed duties after a six-month leave in England. New staff members are: E. Fedorick, pediatric supervisor, and Miss Yaholnitsky, arts instructor.

WANTED

by the

CIVIL SERVICE OF BRITISH COLUMBIA

(OPEN COMPETITION)

STAFF NURSES

(*For the Provincial Sanatorium, Tranquille, B.C.*)

Salary: $174.00 per month rising to $202.00 per month (including current Cost-of-Living Bonus).

Hours: 8-hour day; 5½-day week. (Overtime paid when necessary).

Attractive modern residence. $5.00 per month charged for room — $2.50 for laundry. Excellent food (20c per meal). Recreational facilities. (Bus service to Kamloops, approximately 12 miles.) Exhilarating climate (warm, dry summers; crisp, clear winters).

Annual Vacation: 1 month with pay; eleven statutory holidays.

Sick Leave: 14 days per year (cumulative) plus 6 days for incidental illness.

Superannuation plan. Opportunities for advancement.

Further information may be obtained from the Medical Superintendent, Provincial Sanatorium, Tranquille, B.C.

Application Forms obtainable from the B.C. Civil Service Commission, Weiler Building, Victoria, or 570 Seymour St., Vancouver, to be completed and returned to the Chairman, Civil Service Commission, Victoria.

Director for School of Nursing Education at Dalhousie University, Halifax, N.S. Applicants should have teaching experience in Public Health & Nursing Education. Ability to organize essential & University degree desirable. Salary range: $3,000-3,500. Apply Dr. H. G. Grant at University.

Supt. of Nurses for 118-bed Sanatorium. Apply, stating age, experience & last place of employment, Medical Supt., Brant Sanatorium, Brantford, Ont.

Supt. of Nurses for 40-bed modern General Hospital opening May. Qualified administrator with experience in hospital of similar size required. Duties to commence March 1. Private 3-room suite supplied. Apply, stating references, experience, qualifications, marital status, age, religion & include photo, to Sec., Queens General Hospital Ass'n, Liverpool, Queens Co., Nova Scotia.

Matron for 20-bed General Hospital. 40 miles from Vancouver. Commencing salary: $176 per mo. Separate matron's residence. Apply, stating fully qualifications & experience, to Board, M.S.A. Hospital, Abbotsford, B.C.

1st & 2nd Asst. Night Supervisors for Maternity Division, Mt. Hamilton Hospital, Hamilton, Ont. 40-hr. wk. Straight 8 hrs. 5 nights a wk. Salary schedule—1st Asst.: $1,740-1,920 per annum plus full maintenance. 2nd Asst.: $1,620-1,800 per annum plus full maintenance. (If living out, in lieu of maintenance, $360 per annum living-out allowance is added to above salary.) Apply Supt. of Nurses, General Hospital, Hamilton, Ont.

Night Supervisor for 135-bed hospital. 11-7. 6-night wk. Full maintenance. Obstetrical experience necessary. **Supervisor** for general Surgical & Medical wards. 3-11. Obstetrical experience necessary. 6-night wk. Full maintenance. Apply Supt., General Hospital, Stratford, Ont.

Experienced Operating-Room Nurses (2). Apply in person or by letter to Mrs. B. G. Morris, Matron, Lockwood Clinic, 300 Bloor St. E., Toronto 5, Ont.

Registered Nurses (2) for small hospital in Niagara Peninsula. 8-hr. day. 6-day wk. Salary: $120 per mo. with annual increase. Full maintenance. Apply, stating qualifications, references, etc., to Supt., Haldimand War Memorial Hospital, Dunnville, Ont.

Registered Nurses (2) for Public Hospital, Lamont, Alta. 1 for Men's Medical & Men's Surgical Wards; 1 for Evening & Night Supervisor. Alternate wk. shifts. 8-hr. day. 1½ days off each wk. Gross salary: $139.90 per mo. Deduction for board, room, laundry $19.90 per mo. Increase to value of maintenance after 1 yr. continuous service. Apply Supt. of Nurses.

Registered Nurses for new Pontiac Community Hospital (52-bed General Hospital) at Shawville, Que. 50 miles from Ottawa. Apply Supt.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

General Duty Nurse for Municipal Hospital, Peace River, Alta. Salary: $120 & full maintenance, with transportation from Edmonton. Apply Mrs. Clarke, Supt.

Supt. for 20-bed hospital. Some obstetrical experience necessary. Apply, stating age, experience, qualifications, to Dr. D. H. Dixon, 78 Dundas St., Oakville, Ont.

Supt. to take complete charge of 50-bed General Hospital with School for Nurses. Apply, giving full details of education, post-graduate training, experience & references, to Sec., Board of Trustees, Miramichi Hospital, Newcastle, N.B.

Vancouver General Hospital has positions vacant for **General Staff Nurses.** Salary: $155 (plus laundry) increasing to maximum, $185. Extra $5.00 all-night rotation shifts. 4 wks' vacation & 11 statutory holidays with salary. Superannuation. Sick leave allowances. Registration in British Columbia essential. Apply Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150. and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for General Staff at Tranquille Sanatorium, situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hr. day, 5½-day wk.: $174 per month during 1st yr., $186 per month for 2nd yr. & $5.00 raise per month in 3rd, 4th, and 5th yrs. of service, minus $27.50 for board, room, laundry. 31 days' vacation per annum with pay plus 11 days statutory holidays. 14 days sick leave each yr. accumulative with pay plus 6 days incidental illness. Superannuation Plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Registered Nurses for General Duty (3). Salary: $140 per month with full maintenance. New hospital with fully modern nurses' home in process of building. At present hospital of 30 beds on main line between Saskatoon & Calgary. Town of 1,500. Apply Miss E. Nixon, Matron, Union Hospital, Kindersley, Sask.

Graduate Nurse for General Floor Duty. Salary: $110 monthly. Full maintenance & laundry. Blue Cross hospitalization plan. $60 yearly increase up to 3 yrs. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses for modern 26-bed hospital. Salary: $130 with full maintenance. Straight 8-hr., 6-day wk. Permanent night nurse. 3 wks. holiday with pay after 1 yr. service. Situated 50 miles north of Calgary. Excellent train & bus service. Apply Miss M.A. MacDonald, Matron, Municipal Hospital, Didsbury, Alta.

General Duty Nurses for modern 20-bed hospital. Salary: $135 per month with maintenance. 8-hr. day; 6-day wk. Usual holidays. Apply Miss A. Scott, Mayerthorpe Hospital, Alta.

WANTED BY

• CANADIAN RED CROSS SOCIETY •

Director of Nursing Services for Nova Scotia Division—headquarters Halifax. Public Health Nursing experience preferred.

Registered Nurses for Outpost Services in Saskatchewan, New Brunswick, British Columbia, Nova Scotia, Ontario, and Quebec.

Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply **National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley Street, Toronto 5, Ontario.**

Lady Superintendent. Salary: $175 per mo. & full maintenance. Well-equipped 45-bed hospital. Suite of 2 rooms & bathroom in adjoining nurses' residence. 8-hr. duty. 1 mo. holiday with pay after 1 yr. service. Apply, giving full particulars as to experience, age, etc. Mr. L. G. Crozier, Sec.-Treas., County of Bruce General Hospital, Walkerton, Ont.

Operating-Room Supervisor & Nursing Arts Instructor. Immediate opening. Good location. State Capitol with many civic advantages. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Classroom Instructor, Operating-Room Supervisor for 100-bed hospital in Central Ontario. Post-graduate training essential. Excellent living conditions. Attractive salaries with full maintenance. Apply c/o Box 1, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Graduate Nurses for completely modern West Coast hospital. All-graduate staff. Commencing salary: $160 per mo. less $25 for board, residence, laundry. Annual increment. 44-hr. wk. 1 mo. vacation with pay after 1 yr. service. Transportation allowance not exceeding $60 refunded at end of 12 mos. Apply, stating experience, Matron, General Hospital, Prince Rupert, B.C.

Registered Nurse to take charge of small Clinic. Must be competent in routine office nursing procedure & prepared to learn some laboratory technique & physiotherapy. Staff consists of 2 doctors, nurse, nurse's asst., & 3 clerical staff. 48-hr. wk. with 1 mo. vacation with pay after 1 yr. Apply, stating qualifications, experience, age, marital status, salary expected, references, to Chapleau Clinic, Chapleau, Ont.

General Duty Nurses (2) required for Community Hospital in Peace River District. Salary: $130 per month plus full maintenance. Wire collect to M. F. Malkinson, Fairview, Alta.

Graduate Nurses (2) for General Duty at General Hospital, Salmon Arm, B.C. Salary: $155 gross less $30 for maintenance. Fare refunded after 6 mos. up to $25. 1 mo. holiday with pay after 1 yr. service & 11 statutory holidays. Apply Miss M. Avery, Matron.

Asst. Supervisor for Operating-Room (post-graduate course essential). **General Duty Nurses for Operating-Room.** Post-graduate or experience desired but not essential. **General Duty Nurses** for all depts. Good salary plus high Cost of Living Bonus. For further information apply Director of Nursing Service, Victoria Hospital, London, Ont.

General Duty Nurses for new hospital to be opened Feb. 1. Salary: $125 with full maintenance. Comfortable living quarters. Good bus connections with Edmonton & Calgary. Apply Sec.-Treas., Municipal Hospital, Rimbey, Alta.

Graduate Nurses for General Duty. Salary: $155. Straight 8-hr. duty, 4 wks. annual vacation, 9 statutory holidays. Good living accommodation. Cafeteria meal service. Apply Matron, West Coast Hospital, Port Alberni, Vancouver Is., B.C.

Registered Dietitian to take full charge of dietetics, food purchases, etc. Position requires supervision of all housekeeping & service staff in 85-bed hospital. New hospital proposed in 1949 which will require person capable of assisting with plans, etc. Apply Matron, West Coast Hospital, Port Alberni, Vancouver Is., B.C.
